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The goal of this master's thesis is to investigate approaches to the opioid epidemic in the Piedmont Triad Region in North Carolina. Through interviews and case study methodologies, I examine the history, functions, and resource mobilization of CURE Triad, a local organization fighting the epidemic, and its members. Included in mobilizing resources is first, identifying necessary resources, and second, identifying which resources are not readily available. This case study advances the understanding of how social movements, local organizations, and resources are used to address social problems such as drug use, abuse, and addiction.

ADDRESSING THE OPIOID EPIDEMIC THROUGH RESOURCE MOBILIZATION
IN THE NORTH CAROLINA PIEDMONT TRIAD AREA

by

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TABLE OF CONTENTS

	Page
LIST OF TABLES.....	iv
LIST OF FIGURES	v
CHAPTER	
I. INTRODUCTION	1
II. LITERATURE REVIEW	4
III. METHODS	22
IV. FINDINGS.....	29
V. DISCUSSION/CONCLUSION	74
REFERENCES	90
APPENDIX A. INTERVIEW PROTOCOL.....	98
APPENDIX B. DEMOGRAPHICS QUESTIONNAIRE	100
APPENDIX C. SUBSTANCE USE PREVENTION CALENDAR	101

LIST OF TABLES

	Page
Table 1. Participant Demographics.....	24
Table 2. Participant Motivations.....	31
Table 3. Alternatives to Suspension Programs	42
Table 4. Events Utilizing Connections	71

LIST OF FIGURES

	Page
Figure 1. C.U.R.E. Triad Steering Committee Representation Goals	34
Figure 2. Event Information from Agenda	72
Figure 3. Event Information from Facebook Page.....	73

CHAPTER I

INTRODUCTION

Addiction begins with the hope that something “out there” can instantly fill up the emptiness inside. – Jean Kilbourne.

For decades, healthcare providers have prescribed opioids to people experiencing acute and chronic pain. When used appropriately, opioids can significantly help to alleviate discomfort and allow patients to endure difficult health conditions. However, negative individual and community outcomes can result from the misuse and over-prescribing of opioids. In North Carolina alone, the number of opioid-related deaths climbed from a little over 1,300 deaths in 2014, to almost 2,000 deaths in 2016, and nearly 2,500 fatalities in 2017 (CDC).

Misconceptions about drug addiction have historically resulted in substance users facing highly punitive consequences in the U.S. criminal justice system. However, even with the rise of opioid-related fatalities, legislators have shifted their thought on the treatment of opioid addiction and misuse from a criminal justice problem to a public health issue.¹ Around the country, legislative bodies have replaced punitive laws with both medicalized and harm reduction policies to address opioid addiction, misuse, and the deleterious social and individual consequences linked to heavy drug abuse.

¹ There are likely many factors that contribute to the movement toward less punitive state policies for opioid addiction. See Dollar (2018) for an examination of the racial and class aspects of this phenomenon.

In other words, new approaches are being accepted nationwide. For instance, law enforcement agencies commonly carry naloxone, an opioid antagonist used to reverse an overdose. Although scholars have documented some resistance to these new approaches (Green et al 2013)², the extent to which these innovative techniques are not yet well understood. Further, research is needed to understand what challenges social movement organizations may face when trying to mobilize resources in order to turn new methods into concrete actions—especially when the methods are unpopular.

This qualitative sociological study responds to these gaps in the literature by grappling with two primary questions. First, *how* and *why* have community members in the Piedmont Triad area constructed a local group (C.U.R.E. Triad) to mitigate the opioid epidemic and its negative collateral consequences? In addressing this question, I will also analyze members' motivations to come together, set a vision and goals, and actively work towards achieving them—as well as their achievements towards reaching those goals.

Second, this project will analyze how membership in C.U.R.E. Triad facilitated members' ability to achieve their individual goals. It will be important to analyze the actions taken in both the organization and the members' individual lives because groups consist of more than one entity. Instead, they are individuals, organizations, agencies and groups who coalesce because of a shared identity (Diani 1992). To answer these questions, I will interview ten participants about their experiences with C.U.R.E. Triad, as well as their individual experiences in their professions.

² Green and colleagues (2013) interviewed law enforcement personnel on their opinions regarding the opioid epidemic. Officers of different ranks had negative perspectives on administering naloxone.

Chapter II is a review of the literature on how the opioid epidemic is being addressed. This includes harm reduction and public health approaches that legislators have assisted in replacing historically punitive policies. In Chapter III I discuss the methodology, including steps to ensure human rights protection, and the population studied. I will discuss the setting interviews took place, and the importance of the interview protocol. In Chapter IV, I will present findings of the study in two parts: part I focuses on the social movement organization and their initiatives; part II addresses the actions in the members' individual lives. I will conclude in Chapter V by connecting my findings back to the literature presented in chapter II.

CHAPTER II

LITERATURE REVIEW

Since the Nixon administration, when former President Nixon declared the War on Drugs, drug use and drug users have largely been perceived as deviant and deserving of punishment in a correctional facility (Chiarello 2018). In spite of this, perceptions are moving toward a public health understanding of opioid misuse and addiction, rather than one completely dependent on traditional criminal justice operations such as policing, adjudication, and incarceration. This change in orientation is reflected in part by former President Obama's decision to sign a bill allowing funding to those in search of treatment (Dollar 2018). Furthermore, the political sector plays an important part in the success or failure of most social movements through policy change and implementation (Diani 1992 and Rootes 1997). Below I review key issues related to these aspects of social change through political policies with the assistance of the logic and spirit of resource mobilization theory.

The resource mobilization model is a framework commonly used in social movements research and practice to explore how resources can help contribute to the success or failure of social movements (Jenkins 1983). Before focusing on *how* social movements succeed, it is important to review basic elements of the resource mobilization theoretical framework

Social Movements

Arguably, the main determining factors of a social movement succeeding are: political opportunities, organization, and collective identity and action (Jenkins 1983).

Theorists have emphasized group organization as the key factor in successful resource mobilization (Jenkins 1983). Resources can be material or non-material; both are important to the success of a social movement (Jenkins 1983). Examples of material and non-material resources are provided in subsequent sections.

Social movements are organized by one of two models: centralized bureaucratic or decentralized decision-making (Jenkins 1983). Members who belong to groups with centralized models have clearly defined roles, reducing the risk of internal conflict (Jenkins 1983). Meanwhile, members of an organization with a decentralized structure benefit from interpersonal bonds that ultimately lessen the risk of suppression (Jenkins 1983). Both models are appealing and contribute to the mobilization of resources, however, centralized models are arguably more efficient for mobilizing resources in modern social movements (Jenkins 1983).

Studies have led theorists to believe social movements are developed from long-term changes in the three determining factors mentioned above (Jenkins 1983). I don't disagree that organization, political opportunities, and collective identity and action have large roles in the success of social movements. While the literature shows grievances are secondary to everything else, I adopt a progressive version of resource mobilization theory highlighting social psychological elements.

The primary addition from social psychological versions of the resource mobilization framework is the role grievances have in social movements including how they are interpreted (Klandermans 1984 and Snow, Rochford, Worden and Benford 1986). There are two important takeaways from this: grievances play a key role in determining and shaping participation; and they can be interpreted in multiple ways which can lead to different goals (Klandermans 1984 and Snow et al. 1986).

Grievances can be a major factor in why someone chooses to participate in a social movement. Once the participants' attention is directed towards the cause, there are two ways mobilization occurs: consensus mobilization and action mobilization (Klandermans 1984). Consensus mobilization is when a social movement uses different strategies to work towards a common viewpoint (Klandermans 1984). When an organization reaches out to different people in the community and persuades them to participate, this is known as action mobilization.

Regardless of someone beginning with consensus or action mobilization, the participant conducts a costs and benefits analysis in both processes (Klandermans 1984). Cost and benefit analysis are not a one-time process, but a continuing analysis that can alter participation at any point (Klandermans 1984). If someone determines the reward is no longer worth the hassle, resources can be severely impacted.

There are other factors that can contribute to the backpedaling of mobilizing resources besides cost/benefit analysis. Some scholars would argue grievances can challenge mobilization. There is potentially more importance in *how* members

participate, rather than participation itself (Snow et al. 1986). The generation and life experiences of a member can alter how someone grieves (Snow et al. 1986).

The shared identity of participants is founded on the desire for change in social structure (Diani 1992). Within the context of people being impacted by the opioid epidemic, this model can be adopted to analyze two important achievements. The first is understanding how resources are being utilized to mitigate the opioid epidemic's lethal impacts on the Piedmont Triad community. In addition, resource mobilization theory facilitates the examination of how professionals, organizations, and stakeholders are both in need of and utilizing resources to alleviate individual and community suffering stemming from the opioid epidemic. Both human capital and economic capital are needed to an extent in order to create organizational collective action (Hunter and Staggenborg 1988). However, when excessive amounts of economic capital are available, there will likely be less human capital and vice versa (Hunter and Staggenborg 1988). The second achievement is the transition from solely punitive approaches to including medicalized and harm reduction techniques to address both, the opioid epidemic, and drug misuse and addiction altogether.

Political Sector

Initiatives from State Leaders

One of the most vital aspects contributing to the success of social and criminal justice policy change and reform is political leadership (Chiarello 2018). Politicians and other leaders in power are able to redefine long-term grievances that have existed prior to recognizing their existence. As a result, when publicly voicing their support for a social

or policy change, there is a greater likelihood of a social movement occurring. Examples of this effect include former President Nixon's influence with the war on drugs (Reinarman and Levine 1997).

With changes in leadership, there has been a general and positive shift of advocating for a less "tough on crime" perspective and therefore allowing a new vision through social movement-like activities. More social movement approaches emerged when former President Obama lifted a ban in 2009 that prohibited federal funds to be used on harm reduction strategies and research (Boeri 2018). Political leaders can encourage and support social movements by introducing and instituting policies that allow for easier mobilization. This practice of policy making to further mobilize resources is evident in several states, including North Carolina.

In 2011, the governor of Ohio, John Kasich, set out to create his own team to act against the opioid epidemic (Penm et al. 2017). Members of the Governor's Cabinet Opiate Action Team (GCOAT) included several state agencies and the Ohio Board of Pharmacy (Penm et al 2017). One of the plans enacted by the team involved actively promoting the responsible use of opioids (Penm et al. 2017). When used responsibly, opioids are very helpful in reducing severe pain.

The other goals of GCOAT included expanding naloxone, and reducing the supply of opioids while preventing overdoses (Penm et al. 2017). In addition to the development of this action team, a legislative order was used to impact the mobilization of resources which led to the passing of Ohio House Bill 93. This bill required the development of a drug take-back program by the Ohio Board of Pharmacy, Ohio

Attorney General, and the Ohio Department of Mental Health and Addiction Services (Penm et al. 2017).

Some state legislatures provide a drop-box for medications to be returned at no costs, typically at police stations. The state of Maine has a U.S. Postal mailing system for community members to anonymously return prescription and non-prescription drugs, free of charge (Stewart et al. 2015). The availability of prescription medications can contribute to accidental poisonings and overdoses, making drug drop-boxes a valuable resource (Stewart et al. 2015).

Another example of leadership being carried out to proactively address the opioid epidemic is evident through the actions of Oregon's Governor, John Kitzhaber. He created his own "Prescription Drug Taskforce" (McCarty et al. 2014). Like the action team in Ohio, several state agencies were included in this taskforce. The goals were very similar to that of the Ohio case: safe disposal programs, reduction of opioids in the community, and providing treatment to those who are addicted (McCarty et al. 2014). The difference with Oregon in comparison to Ohio is Oregon didn't have a large focus on naloxone as a resource (McCarty et al. 2014). Similar to Ohio, the Governor of Oregon and his taskforce were able to set in place legislative orders to help enact programs that would monitor prescribing, ultimately reducing "pill mills" and "doctor shopping" (McCarty et al. 2014). Political leadership within a community can greatly determine a lot about what programs and resources are utilized.

Policies can be, but are not always, effective blueprints for reducing opioid fatalities. One common theme observed in the Ohio and Oregon cases is the utilization of

legislative power to create new approaches. The challenges community members face when mobilizing resources to fight the opioid epidemic are greatly diminished by these approaches. This practice of policy making is also evident in North Carolina with several strategies relating to the opioid epidemic. Below I detail some of these policies and changes to illustrate the importance of resources and leadership in making social and criminal justice policy changes and reforms related to opioids. The policies include syringe exchange programs, the Good Samaritan Law (GSL), and naloxone availability.

Resources and the Policies Helping to Mobilize Them

Resources are necessary to the success of social movements, reforms, and public policy changes (Corrigall-Brown 2016). Certain resources are important for the establishment of the movement, while others are required over time (Corrigall-Brown 2016). There are several key resources available that play a role in mitigating the opioid epidemic both at the forefront and over time. Typically, resources that contribute to social movements are tangible (money, facilities, etc.). In cases of limited tangible resources, intangible resources (knowledge, skill, etc.) become even more valuable (Hunter and Staggenborg 1988). Therefore, it is important to give equal credit to both types of resources.

Policies can contribute to social movements in both negative and positive ways. In the case of the opioid epidemic, policy makers use their legislative power to create an outline for addressing the issue in a way that makes sense to them, their constituents, and/or their donors. Additionally, resources are utilized to theoretically make the plans

effective. Limitations are sometimes put on how the resources can be used, making policies potentially ambiguous and ineffective.

In what follows, I will discuss the basics of each resource and the benefits of utilizing them. It will be valuable to understand who has access to the resources to more effectively reach those in need. Specific policies can help to mobilize the resources in high demand.

Naloxone Use and Availability

Naloxone is an opioid antagonist that reverses opioid overdose by attaching to the brain receptors and displacing the opioids, thus neutralizing their effects and restoring normal respiration (Heavey, Chang, Vest, Collins, Wieczorek and Homish 2017; Davis and Carr 2015). The importance of increased availability of naloxone is best understood by the risk of consuming counterfeit painkillers or heroin containing fentanyl, a highly potent substitute for heroin (Fairbain, Coffin, and Walley 2017). For example, Aaron Shamo was charged with manufacturing potentially millions of counterfeit oxycodone pills containing fentanyl (Paul 2019). Some of the pills were marketed as less powerful than what the contents were, raising the risk of an overdose. Overdoses resulting in deaths can be avoided by having naloxone available.

Many first responders (EMTs, law enforcement personnel, and fire rescue) have begun to carry naloxone due to the rise of opioid-related poisonings. In North Carolina from August of 2013 to August 2017, authorities recorded nearly 7,800 reversals (nchrc). Along with first responders, populations without traditional patient-physician relationships can also benefit from naloxone availability. Faulkner-Gurstein (2017)

highlights an effective approach to reaching such populations and equipping them with naloxone.

People who formally used have easier access to the population of active users than practitioners and other public health workers. Expanding access to naloxone increases the likelihood of providing the opioid antagonist to people in active use. Drug use is a social activity; if someone is overdosing, administration of naloxone can be done in a timely manner, making naloxone accessibility an important and key goal in reducing overdose fatalities (McClellan et al. 2017). Another population likely benefiting from naloxone are people currently or recently incarcerated. In the first 2-4 weeks post-release, individuals are at their highest risk of overdosing (Barocas et al. 2015). This points to the value of making naloxone accessible to people pre-release and learning how to use it while still incarcerated (Barocas et al. 2015).

Gaining access to naloxone can be accomplished by a few different scenarios. The first scenario is pharmaceutical companies gifting it to first responders or providing it at discounted values. While this is indeed generous, the capitalistic notion of supply and demand remains true with naloxone prices. As the need for naloxone has increased, so has the price. Many people can't afford the shelf price of naloxone and therefore have relied on gaining access elsewhere.

The first of these is third party prescribing (Davis and Carr 2015). This route involves a patient being prescribed naloxone and then giving it to a friend, family member, or acquaintance (Davis and Carr 2015). Third party prescribing occurs when people do not have the resources to develop traditional physician/provider-patient

relationship. The second of these routes are standing orders. Standing orders allow community-based programs and EMTs to distribute naloxone (Davis and Carr 2015).

Harm reduction methods are becoming more appreciated; naloxone use has received minimal negative feedback (Faulkner-Gurstein 2017). The United States Department of Health and Human Services considers expanding naloxone one of the more important policies initiated for this epidemic (McClellan et al. 2017). Through Senate Bill 20 in North Carolina during the year 2013, practitioners who prescribe, dispense, or distribute naloxone to third parties will not be held liable if anything happens during administration.

In addition, individuals who administer naloxone to a person experiencing a drug-related overdose will also not be held liable (Senate Bill 20, 2015). Standing orders were mentioned as being one of the ways community-based programs are able to distribute naloxone. Furthermore, standing orders allow physicians and other prescribers to authorize someone to distribute naloxone to persons who meet certain criteria (Davis and Carr 2015). North Carolina has both third party prescribing and standing order policies previously mentioned (Davis and Carr 2015). While interviewing participants in this study I will have the opportunity to question which method community-based programs they are accessing and if there are any challenges experienced in doing so.

Although there are copious lives saved with naloxone, along with policies increasing availability, there are still obstacles when mobilizing naloxone. There has been a financial drain due to the increased prices as the number of overdoses climbs. Again,

people at risk can receive naloxone from community-based organizations, however, it can be challenging for organizations to obtain sustainment funding.

Syringe Exchange Programs

Syringe exchange programs (SEP) are defined by the North Carolina Harm Reduction Coalition (nchrc) as a program that allows people to obtain clean sterile needles/syringes and dispose of their used ones. The establishment of illegal SEPs begun in 1988 in response to HIV prevention techniques (Showalter 2017). Over time, SEPs are gaining more support and being effectively implemented.

Syringe exchange programs contribute to decreasing the spread of HIV and other blood borne diseases in part from proper disposal. Tookes and colleagues (2012) compared the number of syringes visible during a walkthrough of selected neighborhoods in two cities. San Francisco had SEPs available, while Miami did not. During walkthroughs they observed eight times the number of syringes in Miami compared to walkthroughs in San Francisco. Miami also had more syringes improperly disposed of than San Francisco. Moreover, another benefit of SEP is the ability to refer and admit syringe exchange participants to treatment programs while providing clean needles (Kidorf, Brooner, Leoutsakos and Peirce 2018).

People who are currently using street grade opioids (heroin) are likely those using syringe exchange programs. Unfortunately, people who inject drugs rarely visit the sites due to the stigmatization of being identified a drug abuser (Brothers 2015). Fear of police, geographic isolation and the inability to visit syringe exchange programs during hours of operation, are all additional barriers to accessing syringe exchange programs

(Brothers 2015). Mobile syringe exchange programs have been implemented in some areas to account for these barriers.

Syringe exchange programs are usually community-based or run by health department outreach programs. Regardless of the entity running the syringe exchange program, there are different sources one can apply for financial aid. The North Carolina Department of Health and Human Services website (ncdhhs.gov) provides a collection of different organizations and foundations to apply for financial help. Going to elite groups for finances has limitations depending on the perceptions of those elites (Corrigall-Brown 2016). If the perceptions follow more moderate goals, limitations might be placed on the methods of harm reduction used (Corrigall-Brown 2016). Prior to July 2019, when a law was passed allowing for state funds to be used for purchasing syringes, organizations relied solely on donations (House Bill 325).

Legalization of SEPs in North Carolina begun when Governor Pat McCrory created a pilot project through House Bill 712 that allowed four counties to have syringe exchange programs (House Bill 712). This bill was passed in 2015, a year before the House Bill 972 made syringe exchange programs legal (House Bill 972). There were three main objectives associated with this bill. The objectives are: reducing the spread of HIV, reducing the risk of needle-stick injuries to law enforcement officers and encouraging individuals to enroll in evidence-based treatment programs (House Bill 972).

Substance Abuse Treatment Centers

Prevention and abstinence are two methods of addressing the opioid epidemic, but what happens when someone is currently addicted to opioids? There are several types of

medications that are used to treat opioid addiction. Recovery goals can be accomplished through the use of opioid substitutions such as Buprenorphine, an opioid agonist-antagonist mixed substitution that has shown to have small dependence characteristics (J.W. Lewis 1985).

Those who are benefiting the most from methadone treatment centers are older (average age of around 34), white and of higher education (Clark et al. 2014). It might not come as a surprise that there are several barriers preventing people in the criminal justice system from receiving methadone treatment (Clark et al 2014). One of the more intriguing and problematic barriers is the perception that criminals shouldn't be allowed to receive methadone treatment (Clark et al. 2014). Although inmates are generally not benefiting from the treatment, studies show people re-entering society could benefit tremendously from methadone treatment (Brinkley et al. 2017, McDonald et al. 2016, Clark et al. 2014). Another substitution for opioids is Naltrexone, a long-acting opioid antagonist that is not a controlled substance (McDonald et al. 2016). Unlike buprenorphine and methadone, naltrexone can be prescribed in any general medical setting (McDonald et al. 2016).

Financial help is possible through two main sources, the first is medical insurance. North Carolina accepts Medicaid for both methadone and buprenorphine treatments (Wickramatilake et al. 2017). Another source of income is through the Center for Disease Control (CDC), which has funded 29 states, including North Carolina (CDC). For the time frame of October 1st, 2016 through September 30th, 2017, the CDC provided North

Carolina \$416,430 for illicit opioid use risk factors and \$2,366,241 for prescription drug overdose ([CDC](#)).

North Carolina has established an action plan for addressing the opioid epidemic ([ncdhhs 2017](#)). In this action plan one of the main focus areas is expanding access to treatment. To do this there are several steps that will be taken, with the first including more funding from state and federal government, in order to provide treatment to North Carolinas residents ([ncdhhs 2017](#)). In the action plan, several populations are mentioned as being especially important when expanding treatment. Increasing the number of OB/GYN and prenatal prescribers who can administer medication assisted treatment, for example, methadone and buprenorphine will expand treatment to pregnant women. Justice-involved populations at reentry facilities and jails are the other special population of focus ([ncdhhs 2017](#)). Similar to pregnant women, there is a goal to provide medication assisted treatment to those at reentry facilities, local community corrections, and even expanding medication assisted treatment in-prisons ([ncdhhs 2017](#)).

Knowledge as a Resource

Educating people on the opioid epidemic can be valuable not just towards the larger community but also within the public health profession. When professionals in the field are uneducated, there's a risk of overprescribing to patients experiencing chronic pain (Phillips 2012). In addition to professionals prescribing opioids, some law enforcement departments are unaware of the laws protecting people from arrest on drug charges when calling 911 in the event of an overdose (Banta-Green et al. 2013).

This section will follow a slightly different format than previous sections. First, there will be a discussion on how education of harm reduction, in addition to zero tolerance and addiction, can help reduce the risk of overdoses. The second part of the discussion will be on the prescribers and what their lack of education can lead to, thus highlighting how important it is for professionals in the field to be well-educated. The concluding part of the discussion will cover the Good Samaritan Law and an overview of the benefits provided by the law. The benefits of the Good Samaritan Law can be overshadowed if substance users and police officers are not aware or properly educated about the law.

Educating law enforcement personnel on positive outcomes of harm reduction initiatives is a way of gaining support for such incentives (Jardine 2013). Harm reduction techniques help reduce crime, a communal benefit (Jardine 2013). It is likely, with the support of law enforcement and government officials, more knowledge can be shared on harm reduction methods.

Schools are another entity vital to reducing opioid related fatalities by educating students on harm reduction. D.A.R.E is a program easily recognized to many people that takes on an abstinence outlook, including a pledge to *never* do drugs (Midford, McBride and Munro 1998). Harm reduction education has slowly become more widely accepted, while keeping abstinence at the forefront of the American approach in schools (Midford, McBride and Munro 1998). Educating the community on harm reduction is beneficial and important, regardless of utilization in schools. Programs that focus on such methods,

show success in decreasing the spread of HIV without increasing use of drugs (Midford, McBride and Munro 1998).

Physicians prescribe opioids to patients who are experiencing chronic or acute pain when deemed necessary. However, it has been observed prescriptions are prescribed too often without sufficient evidence for doing so (Compton, Boyle and Wargo 2015). In order to reduce overprescribing, physicians need to be better educated on pain management and develop relationships with their patients. Allowing their patient more say in their treatment protocol can ensure a joint understanding of the treatment process (Matthias, Parpart, Nyland, Huffman, Stubbs, Sargent and Bair 2010).

The Good Samaritan Law protects those who report overdoses by granting them immunity from minor drug charges, and in some states, this includes drug paraphernalia charges (Compton, Boyle and Wargo 2015; Koester et al. 2017; Latimore and Bergstein 2017). Making the decision to call 911 gives the person overdosing a greater chance of surviving. (McClellan et al. 2017). Being aware of the Good Samaritan Law can increase one's confidence in calling 911.

In a study conducted by Latimore and Bergstein (2017), only one third of participants who witnessed or experienced an overdose were aware of the Good Samaritan Law prior to participating in the study. This obviously indicates a lack of education amongst both the general public and the using population. Additionally, Banta Green and colleagues (2013) found only 14% of police officers in the study were aware of the Good Samaritan Law. Of these, less than half knew the law protected bystanders along with the victim overdosing (Banta-Green et al. 2013). This lack of awareness is

likely accounting for why people who are experiencing or witnessing an overdose do not call 911.

Another factor that could result in people neglecting to call 911 when experiencing or witnessing an overdose, is the fear of being charged with homicide. In North Carolina, the Death by Distribution law just came into effect this past year in July, 2019 (House Bill 474, Senate Bill 375). However, in some states, this policy has been in effect since 2016 (Rothberg and Stith 2018). For example, a 36-year-old man was sentenced in Chicago during the year 2017 for selling drugs to a couple that concluded with a 21-year-old female overdosing (Marrazzo 2017). During the trial, the father of the female voiced his opinion that users need treatment and dealers need to be removed from the streets (Marrazzo 2017). The father's grieving, yet arguably emotional statement neglects the possibility of the small-time drug dealer also being addicted.

Resources, Politics and Their Place in Social Movements

Social movements, reform efforts, and public policy initiatives can become unsuccessful when faced with difficulties accessing valuable resources (Corrigall-Brown 2016). Social movement organizations can generally turn to external sources, for example government agencies, for funding (Corrigall-Brown 2016). Unfortunately, being dependent on elite organizations for valuable commodities can have consequences (Pichardo 2018). Two potential consequences are strict guidelines, and time restrictions on funds (Pichardo 2018).

In conclusion, whether looking at original resource mobilization theories or social psychological versions, it is clear the political sector has a significant impact on

mobilization (Jenkins 1983, Klandermans 1984, Hunter and Staggenborg 1988, Sen and Avci 2016, and McCarthy and Wolfson 1996). Political networking and relationships can assist with much of the funding challenges that social movements encounter. People with former political positions, or, individuals with highly valued reputations in the community, can help turn beliefs into concrete actions (Diani 1992). In organizations without formal representation, power-holders and experts in the field can make demands on behalf of the organization (Diani 1992).

CHAPTER III

METHODS

Two questions guide this research. First, how and why did C.U.R.E. Triad evolve? And two, what role does C.U.R.E. Triad play in the member's individual accomplishments mitigating the opioid epidemic? To answer these questions, I conducted face-to-face, semi-structured interviews with community members actively engaged in mitigating the detrimental impacts of the opioid epidemic. Using a qualitative methodology allowed me to explore the complexities and unique attributes of this organization and topic to be explored more readily (Yin 2014). Making matters more complex is the ongoing shift from addressing users in a criminal justice manner to a public health one.³ Therefore, with the newly innovated solutions and the crisis being an ongoing concern, the descriptive ability of a case study is both appealing and appropriate (Yin 2014).

C.U.R.E. Triad

I gained access and awareness of C.U.R.E. Triad from working with a research scientist at the University of North Carolina at Greensboro on an unrelated project. After attending a monthly meeting with said research scientist, I became interested in studying

³ Criminal Justice methods remain but are now being directed towards macro-level involvements such as pharmaceutical companies distributing opioids at exponential rates. For more details on the pharma distributor Rochester Drug Corporation see <https://www.cnbc.com/2019/04/23/rochester-drug-cooperative-to-pay-20-million-in-opioid-case.html>.

the organization in more detail, exploring what they were doing in the fight against the opioid epidemic.

Thus, the larger goal in conducting this research was to understand how people in the Piedmont Triad are addressing the opioid epidemic. In doing so, narrowing in on a smaller entity allows me to understand in great detail how mitigation is being attempted and accomplished. C.U.R.E. Triad is a relatively new group, founded in 2016. Conducting a case study on this young organization, allows me to witness the beginning struggles that social movement organizations experience when first starting out.⁴

IRB Approval

The Institutional Review Board (IRB) plays a necessary role in making sure research is conducted in a manner that does not cause harm to participants. I had to receive IRB approval for my study before being able to interview members of C.U.R.E. Triad. I filled out the IRB application and submitted it to the University of North Carolina at Greensboro Institutional Review Board. After the first submission, there were minimal stipulations that had to be corrected before resubmitting the application. Once the corrections were completed, I resubmitted the application and received IRB approval. At this point in the process, I was ready to begin interviewing members of C.U.R.E. Triad.

Interviews

Eleven semi-structured interviews were conducted. Ten of these eleven interviews included sufficient depth and detail to be included in the overall study. All ten interviews

⁴ Older organizations are expected to be more skilled and developed, making the likelihood of mobilization higher. (McCarthy and Wolfson 1996)

were with people residing in the Piedmont Triad region and professionally or personally involved in addressing the opioid epidemic. All, of course, were involved in C.U.R.E. Triad to a greater or lesser extent. The interviews lasted anywhere from forty-five minutes to an hour and fifteen minutes. There was no time limit, just the expectations of all pre-constructed questions being answered.

The interviews were inclusive of different professions such as first responders, educators, and public health workers. Below is a table showing the occupations and basic demographics of each participant. Additionally, each participant’s pseudonym is included in the table below. Using pseudonyms helps to organize responses while maintaining confidentiality. All names were created with a random name generator to ensure there are no connections to the actual participant. There is a potential for interviewees to be identified from their job title, however. The participants have been notified of this risk and have given verbal consent prior to conducting the interviews.

While there is diversity in the age range, unfortunately, there is not much variations in the race of the interview participants.

Table 1. Participant Demographics

Interviewee	Job Title	Race	Gender	Age
I “Roosevelt Wilkins”	National Volunteer Coordinator for Safe Project	White	Male	60
II “Shane Hodges”	Founder of the Non- Prophet 108 Challenge	White	Male	46

III “Alvin Rogers”	Emergency Services Director for Guilford County	White	Male	53
IV “Jessie Luna”	Integrated Behavioral Health Clinician	White	Female	48
V “Larry Perry”	Program Coordinator for Guilford County Solution to the Opioid Problem (GCSTOP)	White	Male	26
VI “Sophia Russell”	Substance Abuse Coordinator for Guilford County Schools	White	Female	N/A
VII “Lydia James”	Retired Lawyer and Caring Services Board Member	White	Female	64
VIII “Stanley Stokes”	Justice Involved Program Coordinator with GCSTOP	White	Male	25
IX “Miranda Morgan”	Project Coordinator for Healthy Guilford	Black	Female	45
X “Marshall Patton”	President CEO of Fellowship Hall	White	Male	60

In addition to age, another varied characteristic are the differing careers and backgrounds. The unique and diverse professional backgrounds is one of the reasons that led to the decision to conduct semi-structured interviews. The freedom to ask for richer details on several unfamiliar backgrounds allowed for better understanding of the participants beliefs, motives, goals and struggles in regards to mitigating the opioid epidemic (Barriball and While 1994). In addition to the participants’ professional backgrounds, more than half of the interviewees had personal motives behind their interest in C.U.R.E.

Triad and the opioid epidemic in general. The use of semi-structured interviews allowed for these sensitive topics to be addressed and for participants to share their stories (Barriball and While 1994). The different motives will be listed in a later section.

The initial email to recruit participants was sent by one of the initial members of C.U.R.E. Triad. In the email, she attached my IRB approved recruitment letter. After only hearing back from a few potential candidates, I used the C.U.R.E. Triad directory (that I had previously created) to send out a second batch of emails directly to anyone listed in the directory. Given that the contact information for the directory was collected at a single meeting, less than a third of current and/or past members were included. I then went to the C.U.R.E. Triad Facebook page to send out a third batch of emails, via Facebook Messenger, to recruit the remaining number of participants.

The ten interviews were conducted at various locations, which included participants' offices, Panera Bread, Public Libraries, and the University of North Carolina at Greensboro. Pre-constructed questions were developed based on topics related to C.U.R.E. Triad, their professional careers (roles and duties), how the opioid epidemic is being addressed and their opinions on how addressing substance problems has changed over time (see Appendix A). The scholarly literature reviewed in chapter II helped guide the development of my interview protocol.

Barriball and While (1994) identify three important principles for constructing an interview protocol in semi-structured interviews. The first principle, specification, is ensuring that each question yields data that will help answer the research question(s). Division refers to the order questions are asked, making sure to start off light in order to

develop rapport with my interviewee. The third principle, tacit assumption, refers to determining the true meanings behind the responses I received during the interviews. Structuring each question to guarantee each of these elements is accounted for creates more certainty there will be enough depth in the interviews, along with the ability to interpret any responses thereafter (Barriball and While 1994). The interviews were recorded to confirm there would be no incorrect interpretations on what was said during the interviews (Barriball and While 1994). In addition, each interviewee filled out a survey of basic demographic questions (see Appendix B). A consent form was provided for each participant to review; however, they were only required to provide verbal consent.

After conducting the eleven interviews, I was no longer getting new information or data that helped me further answer my research questions. Indeed, the same information kept being discussed. At this point, and consistent with the notion of theoretical saturation (Morse 1995), I felt confident in the depth of information I had collected and begin transcriptions of the interviews.

Coding and Analyses

The development of themes from careful coding and categorization of interviewee responses is a trademark of qualitative interviewing methodology (Beck, 2003). During the coding process, the researcher brainstorms ways of bringing the data together and analyzing it into major themes (Taylor, Bogdan and DeVault 2016). General insights from the literature became illuminated during the coding process.

There are two main coding techniques a researcher can use, open coding and focused coding (Taylor et al. 2016). The process of rereading the data while noting potential propositions is known as open coding (Taylor et al. 2016). Several categories of material resources and nonmaterial resources were developed during open coding. Throughout the second technique, focused coding, the researcher narrows in on those categories and distinguish all the major themes, typologies and concepts to create a list of fully developed codes (Taylor et al. 2016).

The themes developed from the two forms of coding allowed me to analyze the resources in three main ways: (1) The quantity of diverse resources, (2) how often each resource is mentioned (Beck 2003), (3) and the relative value of resources held by respondents. The synergy between these three analytic strategies helped me to identify current accomplishments, struggles and experiences of the community-based organization I have spent the better part of two and a half years researching.

CHAPTER IV

FINDINGS

There were two main questions, with additional sub-questions, I set out to answer. The first, how and why has C.U.R.E. Triad formed in order to mitigate the opioid epidemic? The second question was how have members used the organization to mitigate the epidemic in their own occupations?

The first section, Part I, will analyze how C.U.R.E. Triad was formed, the mission and vision of the organization and its strengths and weaknesses. In addition, I will identify the resources valued for accomplishing the goals of the organization. I will break C.U.R.E. Triad down into four time periods that I will refer to as generations. The resources valued by the organization to accomplish their goals and vision, will be weaved in throughout the discussion of each generation. As we will see, the majority will be in the form of non-material resources. The distinction between non-material and material resources will become clearer as I proceed.

In Part II I will move on to the resources needed for the individual member's professional accomplishments. This section will adopt a schema common in social movements literature in which resources are categorized as tangible or intangible. Members of C.U.R.E. Triad need tangible resources at an exponentially higher rate in their professional lives than as an organization.

Part I: C.U.R.E. Triad

The lineage of C.U.R.E. Triad shows the importance of studying a community-built organization whose members are coming together to work towards a common goal. It is important to mention that although traditional resource mobilization theorists argue grievances come second to long-term changes in collective action, organization and political opportunities, they appear to come simultaneously in this research (Klandermans 1984, Jenkins 1983, Jasper 2011).

At the roots of C.U.R.E. Triad, is a group of people discussing a concern impacting many of their professional and personal lives. In due time, the matter grew larger and so did the number of people being impacted by the detrimental outcomes. The organization can be divided into four generations: the first generation is known as the “Lunch Bunch.” During interviews, participants referred to the second generation as “Cure”, or the “Solution Series.” C.U.R.E. Triad” is the third generation and the final is an era characterized by rebranding and relaunching.

While researching what members of this local organization have actively engaged in to mitigate the opioid epidemic, interesting suggestions for the upwards and downwards trajectories of C.U.R.E. Triad have been provided by my interviewees. Four main themes emerged when discussing the weaknesses and strengths of C.U.R.E. Triad: structure, diversity, togetherness and attendance. Before discussing each generation separately, it is important to understand what originally brought members to participate in the organization.

Participation

One of the prominent factors initiating the development of social movements are collective interest. Collective interests exist prior to the process of mobilizing resources (Jenkins 1983). Each of my participants had one of four reasons for their initial interest that led to their involvement in the group. Some had more than one driving factor, while others had only one. The four driving forces were their career, their former addict status, a loved one was or is a former addict, or a loved one was lost due to an overdose.

Table 2 shows the different motivations each participant disclosed. This was not a question asked in the interview protocol, but data interpreted from responses to other questions. The category “Former Addict” are participants who used to be an active user, but since have reached some definition of recovery.⁵ “Lost Loved One” refers to any friend, relative, significant other, etcetera, that has died from an opioid-related overdose. “Loved One is User” refers to anyone that currently has a loved one that is an active user. The final category, “Career”, refers to participants with paid or unpaid careers associated with substance use or abuse.

Table 2. Participant Motivations

	Motivation			
Participant	Former Addict	Lost Loved One	Loved One is User	Career

⁵ The word choice of “some definition of recovery” is used to avoid any connotation of a particular form of recovery. There are several different definitions discussed indirectly throughout this paper (MAT and abstinence are two examples.)

Lydia James		✓		✓
Shane Hodges	✓			✓
Alvin Rogers				✓
Jessie Luna			✓	✓
Stanley Stokes	✓	✓		✓
Sophia Russell				✓
Roosevelt Wilkins		✓		✓
Larry Perry	✓	✓		✓
Marshall Patton				✓
Miranda Morgan				✓

First Generation

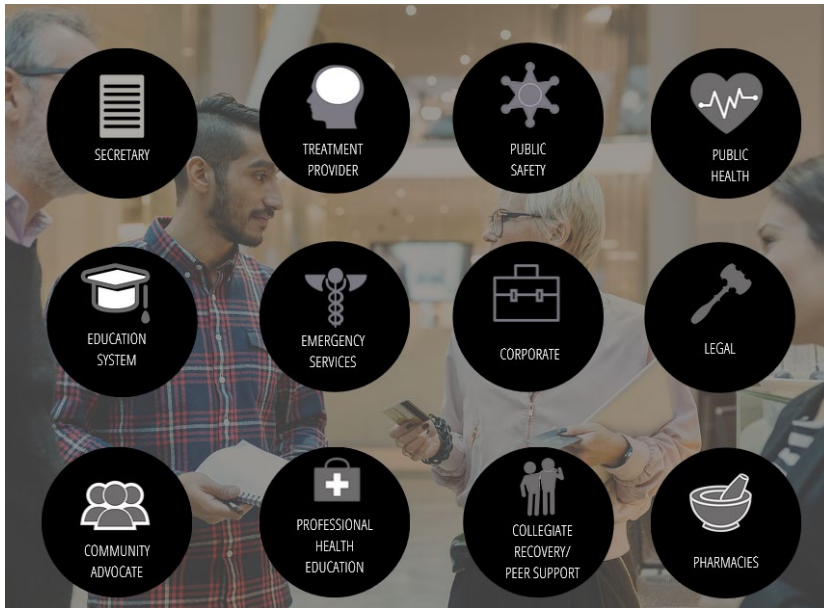
In the rudimentary stage, these colleagues called themselves the “lunch bunch”, and became the first generation of the organization. The group emerged when a representative, Becki Knight, from the Area Health Education Center (AHEC), invited a colleague in the field, working with the Spartan Recovery Program (SRP) at UNC Greensboro, to a roundtable summit in September of 2016. After the summit was over, the two invited several others to join them for lunch and discuss what was being done in response to the rise in opioid related fatalities.

The structure of the first generation can be described as easygoing and relaxed. The only resources utilized were the connections colleagues used to bring everyone together and their knowledge of the opioid epidemic. At this point in time, funding was not a concern nor topic. The easy-going structure of the first generation would prove to be a challenge later in the third generation of what would become known as C.U.R.E. Triad. However, at this point, discussions centering around public health solutions flowed throughout the group of providers, public health educators, first responders and social workers.

Second Generation

After several months of meeting regularly to discuss potential solutions, other professionals in the community were invited to join. Now the conversation became a roundtable forum on how to further address this matter. This second generation came to be known as “Cure”, or the “Solution Series.” This second generation strongly encouraged a multidisciplinary approach. To ensure everyone being impacted by the social issue is represented, every coalition is encouraged to have at least one member from each sector in the community. A list the twelve sectors can be found on the C.U.R.E. Triad website (see Figure 1 for the diagram found on the group’s webpage.) The twelve sectors in Figure 1 are: secretary, treatment provider, public safety, public health, education system, emergency services, corporate, legal, community advocate, professional health education, collegiate recovery peer support, and pharmacies.

Figure 1. C.U.R.E. Triad Steering Committee Representation Goals



During this second generation, a steering committee was also established and built on the premises of the sectors shown in Figure 1. In addition to forming a steering committee, two colleagues from the Greensboro Police Department provided a meeting space at the police department’s training facility in Greensboro. Although the meeting space was the only new resource utilized, the members continued to expand their connections to other colleagues, as well, thus expanding their knowledge of the epidemic.

In addition to initiating a formal structure, the group was tasked with determining the future of C.U.R.E. Triad and what their mission and vision would include. The C.U.R.E. Triad’s mission is, “to bring together community members to leverage our resources and create mechanisms to provide a more unified approach to address addiction in our community (CURETriad).” The vision of the group was also established: “It is the vision of C.U.R.E. Triad to provide clear access points to the resources available in our

community, create more cohesive transitions, unify and educate the public, build and strengthen partnerships with healthcare and other service providers, public safety, education systems, and elected officials on the treatable nature of addiction and services available (CURETriad).” Both the mission and vision of C.U.R.E. Triad can be located on a past meeting agenda. Once these new developments were completed, the third generation was developed.

Third Generation

The third generation, known as C.U.R.E. Triad, was formed when the organization became open to the public, further including everyone being impacted by the opioid epidemic. This third iteration is characterized by different agencies coming together to educate one another and work towards a common goal. Meetings were held once a month and lasted about an hour. Agendas for the meeting were handed out as each person walked into the meeting space, which continued to be the police department’s training facility.

According to all but two participants, at the start of the third generation, having a diverse group of people with unique backgrounds was viewed in a positive manner and considered thought provoking. The depth in diversity can be understood by acknowledging the different agencies represented in the group. The following are only a few of the agencies embodied in C.U.R.E. Triad: ADS, GCSTOP, Fellowship Hall, Healthy Guilford, Caring Services and Spartan Recovery Program.⁶ The benefit of

⁶ I was unable to interview someone from Spartan Recovery Program (SRP); however, it is an important program to mention. The SRP is a collegiate program at UNC Greensboro that is free to all UNCG students

having such a varied assembly is demonstrated in a statement made during my interview with Mr. Perry, a first-generation member and one of the first on the steering committee:

I think the strength is we had a lot of interests at first from the community, uh, people from a lot of different backgrounds willing to help, uhm, from all of the domains touched by this which is virtually everything.

As time went on, the informal roots of C.U.R.E. Triad set the stage for a patchy future. It was a significant challenge trying to move from a casual roundtable forum to a formal discussion setting. Six out of ten interviewees mention, what for them, was the troubling lack of infrastructure. It is important to note, although that's only 60% of participants, three out of ten participants felt uncomfortable mentioning weaknesses of C.U.R.E. Triad. The three participants, Mr. Stokes, Mr. Hodges and Ms. Luna, have only been able to attend a few meetings. In addition to the growing number of members, when the need to feel included started to arise, the diversity began to shift from a resource to a problem. Ms. James, who was asked to be on the steering committee to fill the legal sector, painted a picture of there being too many "cooks in the kitchen."

Even when we kind of agreed on certain goals we weren't really unified in how to get to those goals.

Originally, many founders of C.U.R.E. Triad were excited with the growing number of people interested in attending the meetings. When the group continued to grow, discussions became more challenging to contain, and the excitement faded quickly. Mr.

and provides a recovery support system. For more information visit the website <https://shs.uncg.edu/about-srp>.

Wilkins, a very involved second-generation member of the group, voiced his opinion of the group size changing and the ability to be productive during meetings:

At one point the group grew so large that trying to have a discussion in a group of fifty becomes very difficult if not incredibly well facilitated.

In addition to the organization growing too fast to create a more formal structure, time became a resource problem with almost everyone on the steering committee having full-time jobs. Having prior commitments outside of the group made it difficult for a sole leader to organize meetings and take on administrative duties. Several members quit the steering committee from a lack of time to devote towards extracurricular activities.

Towards the end of the third generation and moving into the fourth generation a new focus emerged. C.U.R.E. Triad was divided into three different groups: prevention, intervention and recovery. Having knowledge on what the current global initiatives were led members of C.U.R.E. Triad to split into these three groups. Those attending the meetings would break out into whichever group they felt most comfortable participating in. Having smaller groups would ideally make discussion more meaningful.

Unfortunately, the organization entered a phase of reestablishment before the groups made any real breakthroughs.

Fourth Generation

The final and current generation, and the one that's been ongoing throughout my research, is a time of rebranding and relaunching, with the relaunching only being discussed. This generation has been filled with restructuring, relocating and determining what the future of C.U.R.E. Triad will be. Ms. Morgan, a second-generation member and

project coordinator for a separate coalition called Healthy Guilford, suggests that C.U.R.E. Triad is going through a similar phase her organization experienced in its early development:

When Healthy Guilford started, it started back in like 2012, it wasn't really a coalition. It was a lot of people pretty much in the substance abuse treatment sector as well as uhm anything in health care. They were like look all these people are having overdoses and we need to do something. So, it started as a work group. They met for about two years. I hate to say it was out of focus but it was just like round and round and round and we know it is a problem but don't know what to do. So, that is kind of how it got started. Then in 2014 we got a grant from Wake Forest and with that grant it gave us a little funding to hire a coordinator to kind of get the group more focus. The name was originally GCMeds. It was originally to try and educate people on the meds. Well eventually we started thinking and we ended up thinking if we should dissolve or what to do and we ended up going through rebranding and all that.

The ongoing primary concern is receiving funding to hire someone that will fill an administrative position. All members I spoke with have prior obligations and struggle with finding extra time to fill this role. Additionally, some of the original steering committee members ended up leaving the group altogether as a response to demanding professional lives. For example, two of the members that fell off the steering committee were part of the Greensboro Police Department. Around the time of their exiting, the meeting location was needing to be rebooked. C.U.R.E. Triad was faced with a new challenge of figuring out where to hold, the now quarterly, meetings.⁷ It is evident with the constant changes in location and the "TBD" for the third upcoming meeting shown in Figure 2., a snapshot from an agenda, that the struggle was hitting the organization hard.

⁷ Meetings were moved to quarterly rather than monthly at some point throughout the third generation. It is difficult to say exactly when this occurred and when the fourth generation began.

A fair assumption is this change contributed to the fourth generation of relaunching and rebranding. Several of the participants who speak to the weaknesses of the organization mention the hope of surpassing the current struggles.

Mr. Rogers, Mr. Wilkins, and Mr. Patton all specifically bring up GCSTOP (an outreach program that will appear in part II) being a great legacy of C.U.R.E. Triad if this is indeed the end of the organization. If anything can be said, the opioid epidemic is impacting people in different walks of life. Whether the organization is coming to an end or continuing onward, the work that the members of this group have done goes far beyond C.U.R.E. Triad. The next section will detail what resources members are using to mitigate the opioid epidemic and ultimately, the work they've done and continue to strive for in their individual lives.

Part II: Professional/Personal

With C.U.R.E. Triad entering into a generation characterized by rebranding, there was not much collective action occurring within the organization. Throughout my time interviewing members, there has only been one meeting held. That being said, focusing on individual goals and aspirations outside of the group has been the only thing members can do.

This section of my findings focuses on what actions are being taking in the members' professional lives and the resources helping to execute those actions. A fair assumption could be made that many of the members still communicate with one another, just not on C.U.R.E. related inquires. Mr. Rogers mentioned in my interview with him that many of the colleagues often intersect in their professional lives. Therefore, even

though meetings have recently been put to a halt, significant attention has continued to be given to mitigating the opioid epidemic in a different configuration. The resources will be categorized in two ways, material and nonmaterial. As previously mentioned, this is common in social movement research (Sen and Avci 2016).

Material Resources

Some common material resources noted in social movements are money, facilities and means of communication (Jenkins 1983). When further examining the interviews in addition to reviewing the opioid literature, several larger themes became evident in which material resources were observed. The themes established were prevention, harm reduction, treatment and accountability. Unfortunately, there are more unavailable material resources than available ones. While this is true, having awareness of the resources highly valued is a royalty in itself.

Prevention

The theme prevention refers to any resource that is used with the sole intention of preventing opioid use prior to the initial use and resulting in later misuse. Two participants, Ms. Russell and Mr. Hodges, discussed prevention in school setting. To understand the changes in approaches used, and the resources currently available, it will be important to briefly highlight the former prevention efforts in school settings.

The D.A.R.E Program made its debut during the 1980's in Los Angeles with law enforcement officers being trained on drug prevention ([DARE](#)). Training law enforcement officers was originally used to put a face on prevention in schools. The D.A.R.E Program is still used in some schools; however, it's not nearly as often as it once

was. Ms. Russell, the substance abuse counselor for Guilford County Schools, informed me this is partly because law enforcement funding was cut, along with the program proving to be ineffective. Even though the program was ineffective, it at least started conversations about drug misuse. Mr. Hodges, a third-generation member who teaches prevention to middle and high school students, suggests a different reason. He proposes it's because the community is no longer as interested in alcohol and marijuana, which are the foci of D.A.R.E. There are, however, several programs that have taken the spotlight.

Mr. Hodges is a member DC Span, a coalition in Randolph county. When going into schools to educate youth on prevention, the members of DC Span will usually take an emergency worker, law enforcement officer, a parent of an addicted loved one and potentially a recovering addict to share their story. One of the main challenges with accomplishing this task is gaining access to schools. The easiest avenue to gain access is by partnering with other agencies who already have already gain entry into the schools.

Ms. Russell mentions two different prevention methods that have been established in Guilford County Schools. There are three alternatives to suspension programs she manages in addition to a prevention calendar (Appendix C). The prevention calendar is not specific to preventing opioid use, however, it does mention over the counter prescriptions and medications. Each month there is a different area of focus, with some months hitting a little harder than others. The other resources available in Guilford County Schools are the alternatives to suspension programs. These programs are *not* required by the schools but are often used in order to keep suspension rates down. Below in Table 3, there is a chart briefly explaining each of the programs.

Table 3. Alternatives to Suspension Programs

Program	Description	Grade
Tobacco Education Program	Two, 2-hour classes at the school and students are provided information on the consequences of all forms of tobacco and encouraged to make healthier decisions.	Middle and High School
Adolescent Substance Abuse Program	Runs from 9:30 am to 4:30 pm at one of two locations (Greensboro or High Point). Students stay on track by doing school work and also getting education on intervention/prevention curriculum. Counted as an in-school suspension rather than an out of school suspension.	5 th - 8 th
Lifestyles Program	Six-hour substance abuse education and early intervention program for students and parents. Classes are at one of two locations in Greensboro during the evening hours. Educates on not only substance abuse but also healthy family relationships.	High School <i>only</i>

Even though Ms. Russell sets up the courses for each program, she typically does less direct services and classes. This is due to there not being enough time for direct services because she is the sole substance abuse counselor for Guilford County Schools. Up until the Safe and Drug Free Schools funding was cut, there were three other substance abuse counselors. Since the funding cuts, her roles have turned more administrative than they used to be. Now, the school administrators rely on social workers to be the point person for substance abuse in schools.

Besides financial challenges, it can also be difficult finding the appropriate time to fit substance abuse curriculum into schools without eating into academics. Currently, High School students learn about substance use in health class which is only taken in

their first year. There are other possibilities, for example, peer led clubs about substance abuse. Ultimately the schools are only required to enforce the curriculum in health class.

Harm Reduction

The strategy of harm reduction takes on neither a punitive nor medical stance, but rather acceptance and tolerance of drug use (Wieloch 2002). Not all harm reduction techniques are perceived equally. Naloxone administration, availability and public use, has been far less debated and criticized than syringe exchange programs (Wieloch 2002). Although harm reduction is a new development that recently has become popular with the rise in opioid-related fatalities, both naloxone administration and syringe exchange have been in the community for much longer. Naloxone has just recently gained attention, but ambulances have been equipped with it for many years. During my interview with Mr. Rogers, he remembered back to just starting out in his career, and having naloxone on ambulances:

We've always had it on ambulances. I've been a paramedic for 35 years and we've had it since the day I started.

On the other hand, syringe exchange has just recently become legal. Mr. Perry explained to me that users would still secretively engage in clean needle exchange:

Yeah so folks have been providing services, but once again, underground, not funded, so not a lot of people or not a lot of supplies. Well, I mean, not as much as there could be, they did a great job for what they had.

As mentioned in the literature review, naloxone is an opioid antagonist that reverses opioid overdose by attaching to the brain receptors and displacing the opioids,

thus neutralizing their effects and restoring normal respiration (Heavey, Chang, Vest, Collins, Wieczorek and Homish 2017; Davis and Carr 2015). Fifty percent of the participants (5 out of 10) directly mention naloxone in my interview with them. One of the ways naloxone has been used in mitigation is by allowing the general public to have access. There were several avenues to getting naloxone mentioned in the literature review. Two of those avenues were identified during the interviews.

Multiple organizations were represented by participants in this study that have received funding from the CDC or elsewhere, to distribute naloxone to anyone posing a risk of either experiencing an overdose or witnessing one. Both the project coordinator for Healthy Guilford and the project coordinator for GCSTOP has either had or currently has naloxone to distribute. The organization GCSTOP still has an abundant supply that is not only given when making contact with recent overdose victims, but also given at syringe exchange sites. Ms. Morgan, the project coordinator for Healthy Guilford, mentioned having funding in the beginning years that was put towards purchasing naloxone. The naloxone was given out to the public every Wednesday and Thursday until the funding ran out. Even though policies have made it easier for the distribution of naloxone, the obstacle of funding remains.

Time limitations are often a challenge when receiving grant funding. Meaning, if the money received is not used by a certain date, the remaining unused balance has to be returned. There are also other limitations with grant funding. Indeed, another struggle with naloxone funding is the restrictions placed on grants in regards to how the naloxone can be distributed. For example, North Carolina received funding through the CDC for

naloxone, but was unable to use the supply in the public safety field. This meant the naloxone could not be used on ambulances, patrol cars or fire trucks. It had to be distributed to the general population. Receiving naloxone kits to give the general public was a win, the win just came with a lot of restrictions attached to it. These restrictions have led to people in the public safety field getting hit hard by the increase in prices on naloxone. Mr. Rogers mentioned specifically the differences in prices that he has experienced while working in the public safety field: “I went from paying \$4 in 2014 to paying \$48 for naloxone today.”

An additional strain is the stigmatization that leads to discrimination against some buyers. Select pharmacists won’t sell naloxone, even with there being a standing order for it. Furthermore, people are continuously being stigmatized by their appearance. If someone’s appearance resembles that of an active user, then they are more than likely not going to be sold naloxone over the counter. Mr. Stokes described an experience him and his friend had and the different outcomes from two separate occurrences:

You know I went to a pharmacy and I asked them and my friend went up the street to another Walgreens and asked if he could purchase naloxone and he was told no so I was like it kind of raise a red flag so I said hmm I wonder if Walgreens are like that and I went to one right down the street and ask and they were going to sell it to me right on the spot. I also asked if I could purchase some syringes and they said yes but they said they don’t sell syringes to everyone so if someone looks like they’re going to do drugs they’re not going to sell to them.

Although the benefits and importance of naloxone have clearly been stated, not just by my participants but multiple scholars (Yokell et al. 2011, McClellan et al. 2017, Faulkner-Gurstein 2017, Davis and Carr 2015, Heavey, Chang, Vest, Collins, Wiczorek

and Homish 2017), significant challenges are still being faced. There is stigmatization that naloxone encourages drug use; but this argument can be combated by the literature. Unfortunately, another form of harm reduction receives even more stigma and criticism than the use of naloxone.

Mr. Perry, the project coordinator for GCSTOP, is the only participant to mention having a role in syringe exchange programs. Other participants made comments regarding syringe exchange programs as a whole, however, not being directly involved. This participant explains that users can bring their used syringes and exchange them for clean syringes in an effective effort to reduce the transmission of blood-borne diseases.

The difficulty with syringe exchange programs (SEP) is twofold. The first obstacle is funding for the supplies. In addition to funding barriers, the large number of critics challenge the legitimacy for syringe exchange programs. Although there is still much skepticism from the public, some legitimacy has been restored by Governor McCrory when he put a syringe exchange pilot in place during the year 2015 (House Bill 712).

In spite of these difficulties, private donations have made purchase of syringes a lot easier contrary to opinions held by Catherine Corrigan-Brown (2016) regarding the difficulties of outside funding from elite patronages.⁸ The notion of outside funds being easier to purchase syringes likely is the result of strict laws against the use of government funds. Prior to December of 2019, when a new bill was passed, the majority of funding

⁸ There are several risks taken when an organization receives outside funding from elites. One of the main arguments is elites might redirect the movement towards activities accepted by the larger society. See Corrigan-Brown (2016) for more on risk associated with funding from elite patronages.

has heavily relied on private donations. The bill that just went into effect about two months ago, now allows for syringes to be purchased by nongovernmental *and* governmental funds (House Bill 325).

The second challenge is the criticism placed on syringe exchange programs that further stigmatize people who inject drugs. It is a fair assumption that the unfavorable opinions on syringe exchange programs is the reason for limited programs available. During one of the interviews I was given a paper with opioid related resources. The entire front and back of the paper were filled, with only two of those resources being syringe exchange programs.

Opinions towards harm reduction varies and fluctuates even throughout the provider and public health field. Two participants, Mr. Stokes and Mr. Perry, who happen to be the two youngest at ages 26 and 25, highly support syringe exchange to the point of seeing benefits in safe injection sites. Those are sites that users could go to and be safely monitored while being dosed with clean medical grade heroin. Both participants reference other countries that already have safe injection sites, for example Vancouver, and the success these countries have experienced in reducing mortality associated with overdoses. Another participant, Mr. Patton, is in support of harm reduction but only to an extent:

I think harm reduction is a good thing, needle exchange, all those things are useful. But I think the pendulum has swung in some respect to what I call addictions support. Where there is this community, if you will, that want to make it okay for people to continue to use drugs and I'm opposed to that.

Regardless of the amount of support one has for harm reduction strategies, there is agreeance on the importance in educating the public and active users on the benefits of harm reduction. One of the single greatest policies, the Good Samaritan Law (GSL), can be considered a harm reduction technique. As stated in the literature review, the GSL protects people from being arrested when calling 911 in the case of an overdose. The following statement mentions both political support and the positive outcome of the GSL:

You know the governor came out last week, week before, made the announcement for the first time in five years opioid deaths were down in the state of NC. Opioid overdoses have risen, deaths are down. What this means is they are getting reversals, they're not using alone, they are making sure somebody is there with Narcan, they are listening to the GSL more and dialing 911 without fear of being arrested and that is a lot of what GCSTOP is about.

Implementing policies such as the GSL will help to increase positive outlooks, however, it will not be enough on its own. The choice in narrative used can help the general public and first responders understand the benefits of harm reduction. Below are examples of two different narratives provided during the interviews:

I have always struggled with weight all my life and you know wanting to lose 100 pounds. Well the way to lose 100 pounds is to first lose 5 pounds.

You know cars are dangerous, drugs are dangerous. So, what do we do? Before a couple years ago it was more likely to die of a motor vehicle accident than an overdose. So, what do you do just not drive cars? Well no. That's the just say no approach. Well that didn't work for drugs and it hasn't worked for drugs and it isn't working for motor vehicle crashes so what do we do? We put seat belts in them and we put air bags in them and have traffic laws. That's harm reduction techniques.

Staying positive and encouraging people in active use every step of the way is ultimately one of the most significant decisions that can be made. This is best said Ms. James, by a participant that lost their son to an opioid overdose:

Of course, we would like people to be clean and sober but let's kind of encourage them for every positive step they take along the journey. Some people can go from point A to point Z but a lot of people have to do it incrementally so if we can encourage them and say oh wow this is okay good for you, you know.

Treatment

The category “treatment” will not only cover treatment options, but treatment facilities as well. Treatment options and accessibility were the two concerns brought up by every participant. First, I will discuss what participants had to say about accessing treatment, followed by the challenges with the different treatment options. Unfortunately, this section will be dedicated to resources that are unavailable rather than being in great abundance.

Limited physical space was frequently discussed in the interviews. It is pivotal to have entry into treatment at the exact moment an active user is ready. If required to wait any length of time, the user will likely change their mind:

Access to treatment continues to be a struggle. If people have the means we have options but even then, the options uh the number of people in the treatment community are overwhelmed so it's an issue of identifying the right treatment for the right patient. Its opportunities to have access and to have access at the point when they are ready to seek treatment. We have this barrier where people are ready to go to treatment today but there is no room.

The lack of space available for treatment is even more challenging for pregnant women. Only select treatment facilities are equipped to treat women who are expecting. On the list of opioid resources mentioned previously, only two of the five detox facilities accept pregnant women. Additional concerns, for example, women fearing their child will be removed from their custody upon birth, lead to forgoing treatment. Ms. Luna, an integrated behavioral health clinician, advises such fears can lead to foregoing prenatal health care altogether.

Program and patient requirements are part of the reason there is limited treatment space available. Certain facilities only accept patients with either Medicaid, or who are uninsured. Several services only accept patients with private insurance and others accept all forms of payment. Participants working at locations only accepting private insurance voice concerns for not being able to provide enough scholarships for those who are uninsured. In the meantime, when they receive phone calls from people who aren't insured, they will refer them to a facility that will accept them. Unfortunately, the concerns of limited space are further unpromising at that point:

We try to refer them to somewhere that you don't have to have insurance. Daymark, ARCA, who have huge waiting list and who have huge bureaucratic issues, it's a whole other conversation.

Without financial burdens, there are still requirements acting as barriers to treatment. A few of the requirements mentioned can be summed up with a comment made by Mr. Perry, the GCSTOP coordinator:

They make it really hard for folks to get in and really hard for folks to get in having all these requirements like intensive outpatient, groups, counseling. Year analysis, all these different things that are preventing people from well are allowing them to withhold medication from folks.

The requirement of intensive outpatient (IOP) is referring to Medication-Assisted Treatment (MAT) that is fairly controversial in the provider field.

As discussed in the literature review, MAT is the use of medications to help with recovery goals. Even though there are significant benefits to methadone, buprenorphine, and suboxone, the perspectives on MAT in the treatment field are not in agreement. Regardless of differing opinions, there has been some political legitimacy advocating for MAT. Governor Roy Cooper of North Carolina, passed a policy extending the amount of buprenorphine providers can prescribe, as well, the number of patients they can see for MAT. Acceptance of MAT can be understood as being on a spectrum with one end being complete acceptance of however long it takes the user. The other end of the spectrum is having no tolerance for MAT and believing abstinence-based treatment is the true form of recovery. This end of the spectrum is applicable in oxford homes that have a strictly abstinence only environment (Leonard, Olson and Foli 2008).⁹ The middle areas of the spectrum are the beliefs of using MAT for short periods of time, in addition to other therapies and outside support. Mr. Patton, a first-generation member and CEO of a local facility called Fellowship Hall, has more of the middle level viewpoint:

⁹ Oxford Homes are houses that recovering addicts can live in when they exit a plethora of facilities and are working towards getting back on their feet. However, abstinence is non-negotiable. See Leonard, Olson and Foli (2008) for more on oxford houses.

The research is very clear that the longer you can house someone with support the better their outcome will be. So, if you can get someone on a taper for 30, 60, 90 days, get them on vivitrol with housing, with ongoing therapy support, with job placement, with family involvement, those people will find their will to success.

There are many conflicting opinions in the addiction recovery field. Most of these differing beliefs surround harm reduction initiatives such as MAT. The following statement is an elaboration of Mr. Patton's beliefs on what others are doing in the field with regards to MAT:

There are a lot of providers that aren't doing that. You go to a pill mill once a month for five minutes and he gives you your suboxone you might as well be shooting dope far as I'm concerned.

Discrepancies in the beliefs towards MAT are not the sole inconsistencies in the provider and public health field, however, they can contribute to stigmatization that keeps active users from seeking treatment. Another topic brought up that reflects the differing of opinions in the field was fraudulent treatment programs. Mr. Perry, a former addict and now project coordinator for GCSTOP, said the following about traditional models and their use today:

Even mainstream treatment providers usually operate under twelve step models which is already a free service in the community since 1935 and they're charging money, people money for it.

This points to a lack of education on basic treatment options and billing procedures that is costing people more than they can afford. The CEO of Fellowship Hall, a facility

accepting only private insurance, detailed more of the fraudulent accusations in the addiction industry:

I can tell you the addiction industry around the country is at a crossroads in a lot of respects. There are the private equity money for-profit avenues, the false claims of poor ethical practices. You know we're getting Fellowship Hall trademarked. Because you can go online sometimes and type Fellowship Hall and be directed to some for-profit call center in Florida that is brokering patients to the highest bidder. I just filed a complaint with the national association of treatment providers last week because of another provider who was doing some really super unethical business practice was talking about us in a way to draw people to their place. And that's wrong. You know that's just wrong.

In addition to MAT and fraudulent business practices, another area that needs significant altering is treatment availability in jails and prisons.

Five out of ten participants mention easier access to addiction services in jails and prisons being a priority. There are loads of active users in penitentiaries detoxing on their own. Ms. Luna, a second-generation member and an integrated behavioral health clinician, told me about her daughter who got arrested and was left to detox on her own. She also explained there is a high risk of miscarriage for pregnant women who have no assistance when detoxing. I received multiple assumptions for why active users are being left to detox on their own. Ms. James, a second-generation member and retired attorney, mentioned that doctors are contracted out but use their own judgement as to if someone needs medical attention or not. Stigmatizations will likely lead to the latter. Additional beliefs are correctional officers and staff don't identify with helping inmates get treatment as being part of their job. Obviously, my participants thought differently.

Correctional officers and staff should be prepared, especially if someone comes in with drug paraphernalia charges. The jails are filled with people detoxing on their own, which can have extreme consequences as mentioned above. One solution provided was having treatment services within the walls of confinement. Every prison should have an “award-winning treatment facility.”

Currently, Mr. Stokes, a third-generation member and justice involved coordinator for the GCSTOP program, goes into the Guilford County Jail and speaks with inmates about harm reduction mechanisms. Additionally, he tries to get them treatment while they are incarcerated. A lot of the inmates don’t know first and foremost, that treatment is an option and secondly, there is free treatment available. The unfortunate part, there is not enough funding for multiple advocates to do this, leading to many inmates being missed.

Besides treatment in correctional facilities, more than 50% of the participants in this study feel there is one other piece in particular that is missing, a holistic approach to treatment. The following are a couple comments made on needing treatment that addresses all health concerns, mental and physical, and what that would look like:

So, we spend a lot of time uh pulling people out of the river that’s got lost in addiction but I think we need to spend equal amount of time finding out where they are falling in. So that prevention education and awareness is so huge. Let’s find out where they are falling in at.

You know a lot of drug use stems from trauma. Russell Brand has this quote that you know the gateway drug is not weed or nicotine you know it’s trauma. And that is so true you know a lot of drug use stems from first childhood experiences and I think once we can get to the root of those, we can really make a difference in the micro interpersonal level.

I think the other thing that has really opened up my mind is the issues of adverse childhood experiences and the impact uhm it really opened me up. I actually for years served on a student health advisory council of the schools but they do a youth risk advisory survey every year. And if you look at risky behavior, the younger when the risky behavior starts the more difficulties, they have managing it in adulthood.

The lack of a holistic approach is likely because many people still view drug use as a choice. Attached to this is the belief that users deserve what they have coming for them. The lack of empathy in the public's opinion is most definitely impacting the ability for community-based organizations, such as C.U.R.E. Triad, to mobilize resources in the fight against the opioid epidemic.

Accountability

Regardless of the treatment, once someone is in recovery, in order to remain clean, they must continue to hold themselves accountable. Mr. Hodges was the only participant to mention a resource tool that can be used to help maintain recovery expectations for oneself.

This participant founded a non-profit organization that provides a unique method of holding people in sobriety accountable. The 108 Challenge was named after the 108 stitches on a baseball. Those who want to participate in the challenge can pay \$10 for a 108 Challenge baseball, and each day they remain sober they mark a stitch on the baseball. Once all stitches have been marked the person can start on another baseball.

There was far less mentioned for post-addiction than there was for pre-addiction and intervention. Two participants did mention the struggles people face when exiting

treatment, but not many solutions to those problems were stated. Additional information on the difficulties people face will be discussed in a later section.

Funding

Money often costs too much. – Ralph Waldo Emerson

The most discussed topic when learning about the material resources needed was funding. Every participant experienced frustration as a direct result of limited funding. These obstacles all impact the number of people receiving help to reach their defined state of recovery. There are multiple reasons for limited funds that are important to acknowledge.

Sixty percent (6 out of 10) of participants bring up the limitations and strict requirements they have experienced when receiving grants or other sources of funding from local and federal government agencies. Time limitations are a large burden, especially for non-profit organizations. Mr. Patton, although not part of a non-profit, details the experiences of someone who is:

I know one local provider got a \$400k grant and they got it in like May, end of May. And it had to be used by the first of August and it could only be used for new patients. So, what are they going to do, put an ad in the paper? “If you are using drugs come see us, we have money.” And what they didn’t use they had to give back at the first of August. What non-profit wants to give back money?

This type of scenario was mentioned several times when discussing the material resources that participants use in their roles of addressing the opioid epidemic. The quote just mentioned also leads into the next burden that several people have faced, which are

strict requirements and guidelines attached to funding. Often, when receiving grants, there is not a lot of flexibility with what the funds can be used for:

Right, and you don't get any money after that point most of the time. And then the money has to be spent based on what was written in the budget so there's not really any flexibility in spending.

Ms. Morgan, the program coordinator for Healthy Guilford, also mentioned the strict guidelines with grant funding. Per the grant they received, Healthy Guilford is only allowed to focus on youth ages 3-17, rather than all ages.

The process of applying for grants can lead to multiple hoops to jump through as well. Numerous obstacles can arise when applying for a grant. One that was mentioned is organizations having to apply under a separate agency. Since the organization Healthy Guilford was not their own entity, they were required to apply under the Alcohol and Drug Services' agency (ADS).

Besides the basis of grants, there can be separate issues with receiving funds. Several participants described the challenges of working with the local LME-MCOs (Local Management Entities- Managed Care Organizations):¹⁰

But we've approached the local LME and it was a good conversation with them. It's just their funds are very tight. They have an organization they're trying to run; they're not accepting any new contracts. They talked about their rates with us and there is no way for us to make it work.

¹⁰ Per the North Carolina Department of Mental Health and Behavioral Health Services website (ncdhhs.gov); LME-MCOs are "public managed care organizations that provide a comprehensive behavioral health services plan under the NC 1915(b)(c) Waiver for people in need of mental health, developmental disability or substance use services. LME-MCOs are regionally based."

Only one participant showed an ounce of sympathy by bringing up limitations the agency has when dividing funds. The LME-MCOs received a subsidy from the federal government for North Carolina but this too, had difficulties. North Carolina received 31 million for two years, 16 million one year and 15 million for the second year. The money would then be distributed to *all* of the LME-MCOs, coming to 1 million once distributed. With all the challenges, I asked the participants what they think solutions could be to all the madness.

Although not mentioned as a solution, Ms. James recalled a time when the funds were distributed county by county, rather than distributed regionally. This could demand local accountability in order to do what is most efficient for each community. Another solution proposed that has some local legislatures support, would be to defund the LME-MCOs. If defunded, states would have direct contracts with the government. Reasoning for support behind defunding the LME-MCOs was briefly described:

So, you read the news and you see what's happen to the LMEs. One of the LMEs last year was taken over by the state because there was such a misuse and abuse of state funds and pay scale people were getting and the amount of money the LME was sitting on. There are some serious complaints about the system.

A simpler solution mentioned by participants was to have sustainable, non-restricted funds. This would allow participants to use the money with flexibility, in addition to keeping the money for an unlimited time frame. The latter solution, although simple in thought, might not be as simple as one might hope. The role of public opinion's must be taken into account regarding funds:

But there are a lot of, it is just winning the hearts and minds of the people. You know beyond just government policy, because that is what drives the government policy. How people think is what changes what the government is going to prioritize.

There have been many challenges, whether funding or public opinion and acceptance, when mobilizing the material resources that were discussed. For the most part, the opposite can be said about nonmaterial resources that will be discussed in the subsequent section(s). It can be assumed that this is because when nonmaterial resources are limited, there must be an abundance in other resources for a social movement to succeed.

Non-Material Resources

An investment in knowledge pays the best interest. – Benjamin Franklin

Intangible resources often are referred to as “human” capital and form the very being of social movements (Jenkins 1983). Fewer nonmaterial resources will be discussed, nonetheless, this shouldn’t take away from the value given to nonmaterial resources. In other words, fewer difficulties were observed with mobilizing human capital than economic capital. For example, ten out of ten participants (100%) had some form of knowledge on the opioid epidemic. Knowledge can be considered a vital intangible resource that is irreplaceable. Therefore, human resources are likely being relied on extensively due to the limitations of tangible goods. After reading through each interview multiple times, the main theme, knowledge, became abundantly clear. Knowledge can then be divided further into two main groupings: knowledge on the

resources available and knowledge on the myths and realities of substance use disorder. Having familiarity about the options available to people either seeking treatment or harm reduction techniques falls under this first subcategory. Additional knowledge on substance use disorder is used in two different ways. Participants either used their insights on substance use disorder to educate the public or utilized their insight to build relationships. Building relationships can be difficult when trying to gain the trust of active users, but is possible through peer support. Educating the public and building relationships are both used to destigmatize drug addiction and encourage users to seek treatment.

Resources

The subcategory “Knowledge on Resources Available” refers to having information about what treatment options and/or harm reduction programs are available. Of the five participants who directly mention advocating resources, at least four of the participants have experiences with substance addiction either them personally or a loved one.

Three of the five participants mention being randomly contacted by individuals who had found themselves in a situation needing immediate access to treatment for themselves or a loved one. Knowing what is available and the requirements for each of the options is extremely valuable in helping guide people to the program that best fits their needs. Mr. Wilkins provided an inside look at some of the question he follows up with when contacted:

And that's when I start looking and start to ask different questions because I'm not a professional counselor in the field right? But I know a lot of resources locally that can help kind of guide those things. So, I start asking is there insurance, have they been through detox, are they ready to go do they need detox, where are you, uhm are you in Greensboro or Winston Salem?

There are other resources that are advocated for besides treatment and harm reduction.

Whether someone is exiting treatment or just finished jail/prison time, there are many obstacles they will face. Ms. Morgan reflected on what she might experience in this situation:

Okay so, I was just in treatment for 45 days and now I am still out here in the world by myself so what do I do? Where do I go? Where do I find housing, or transportation? I know for me I have enough daily stress in my life but if that was me it would be like oh my god, I would literally want to give up.

Exiting from doing prison time can include unique situations that one might not think about. If the inmate has spent enough time that the culture has changed, there likely will be a huge education gap to face. Ms. Morgan was personally enlightened by this scenario:

One night I was actually at a Narcan (naloxone) packing party and there was this guy there and he was so fascinated with his phone. Funny thing is it was a flip phone. I'm like god what is so fascinating with his phone. Eventually we start talking and he had just gotten out of prison and had been in all these years for drug charges. When he went in, they didn't even have phones. So, he was just like you know something so simple.

Having professionals advocating for even the smallest challenges can make the world of differences.

Substance Use Disorder

There are two methods of educating on substance use disorder included in this next subcategory. The first way is by educating the public with the hope it will help reduce the stigmatization that users face. The second way is eligible when advocates gain the trust of active users and are able to build relationships and provide peer support. This is often accomplished through shared stories about lived experiences. I have become more aware of the stigma and biases towards people with substance use disorder while conducting this research. If others take the time to learn, they too will be amazed at what they uncover.

Educating the Public

There are multiple reasons for educating the public on drug use. The impact that policies have on users' lives is one of the more important reasons for educating the public. Users face even more stigma through the policies passed when decisions are made by people who don't have a clear understanding of substance use as a disorder. I asked one of the participants, Mr. Perry, if they think it's possible for someone without knowledge on substance use disorder to work towards mitigating the opioid epidemic and this was his response:

No, I think we see the consequences of that everyday where funding goes towards folks everyday who don't have an understanding of uhm drug use or uhm how to reduce harm from drug use and the vast majority of our policies and systems are based on no evidence.

One of the policies that many participants brought up, and the one this participant is speaking on behalf of, is the Death by Distribution. As previously mentioned in the

literature review, the Death by Distribution law allows for prosecutors to charge dealers with homicide if someone dies of an overdose from drugs provided by the dealer. The following is a description of the policy according to Mr. Stokes, the justice involved coordinator for GCSTOP:

You know a law was just passed in North Carolina where if I give somebody drugs, they die from an overdose I can be charged with second degree overdose. You know they're not going to get the big dealer you know they're going to be getting mothers who have a sick son or you know if my son is sick and needs heroin to feel better you know I'm going to do that for him because that's my son and I'm involved you know drug trade is part of drug use and you know if I give him heroin and he ends up dying because of it I can be charged with homicide and that's not fair.

Mr. Stokes also shared his personal experience of losing a friend as a direct result of the death by distribution law. Mr. Stokes had a friend who was living in Chicago when he experienced an overdose in October of 2018. The person who was with him feared he would be charged with homicide if he called 911 in an attempt to save Mr. Stokes friend, but they were to die regardless of calling. Rather than potentially saving the young man overdosing, he took precautions to not get in trouble with the law by taking the tags off the car and making the vin number on the car ineligible to read. The Director of Emergency Services for Guilford County also voiced his concerns with the Death by Distribution policy discouraging people from practicing the Good Samaritan Law.

What I don't want to have happen is someone purchases drugs; they use with someone else and there is an adverse outcome and now that person gets charged with death by distribution because their motivation for calling 911 at the point of the overdose diminished

Having uneducated leaders has led to several different downfalls with policies such as this one. Other detrimental outcomes have been the distribution of funds towards less effective areas, for example, faith-based organizations. Faith-based communities have been absent in the fight against the opioid epidemic. Ms. Morgan suggested potential reasoning behind the absenteeism by sharing her personal experience trying to include a faith-based organization:

It is very difficult and I think part of that is because the church is uhm, they are kind of on their own. They shelter their own. I hate to use the word denial but...

There are some exceptions within the faith-based community; GCSTOP has a syringe exchange site at a local Greensboro church. This could be a result of Mr. Rogers prominent role in GCSTOP and the connections to well-respected organizations and groups that Mr. Perry has gained access to through Mr. Rogers.

Uneducated leaders have also led to less evidence-based policies. I asked for more details on this and was informed of the systemic policies perpetuating stigma, for example, mass incarceration, criminalization, and interdiction of drug use. Although making a previous point of this resulting from uneducated legislatures, it could be argued that the policies do not fully come from uneducated politicians. Mr. Perry argues education is pivotal but nonetheless, also mentions education only going so far:

It's the same politicians that have passed the progressive policies...It's their dissonance. It is their inability to see things from a public health lens and not a criminal issue so they still see folks as criminals. And then also institutionalized racism comes into play. People think that they are trying to protect the rick white boy that's buying heroin from these black drug dealers.

It became evident that both criminal justice and public health perspectives are still practiced in the community. Although most participants saw the negative outcomes that result from policies like the Death by Distribution, there were a few in agreeance with some criminal justice measures having a place in mitigating the opioid epidemic. Those who agreed there is a place for punitive measures were ages 40 and up. Meanwhile, participants in their 20s had a collective belief for decriminalization of all drug use.

Another important factor for educating the public is to humble the discrimination and negative perspectives held by first responders. The following is an encounter with one of my friends on Facebook and highlights the unreliable information provided by some first responders.

Although this knowledge didn't come from a participant, I felt it was extremely important to include. A paramedic for Forsyth county made a Facebook post about being a former addict, now in recovery and giving back to the community through her role as a paramedic. In the post, she makes an attempt to educate people on the reality behind substance use disorder. In addition, she mentions something I want to focus on, EpiPens. The majority of first responders, law enforcement, fire fighters and others in the public service field, have brought up EpiPens and questioning if they should they carry naloxone if they don't carry EpiPens. Similarly, they mention how expensive EpiPens are. She addresses this in her Facebook post, stating that there is no epidemic on EpiPens anymore. The cost of a pack of two pens is around \$30. In addition to this, through speaking with Mr. Rogers, who is over the budgeting for the emergency services department for Guilford County, it appears as though the determination to carry EpiPens

is the department's choice. If deemed necessary enough, the department can fit that into their budget, just as they have naloxone.

The blame being placed on users is uneducated and points to the dire need of refining the larger communities' assumptions. The example provided gives a wonderful look at someone who has endured addiction, gone through treatment, and is now in recovery and giving back to the community. This also speaks to when Mr. Rogers mentioned to me that first responders only see users at their lowest points. They never see them when they are in recovery, giving back. When it comes to educating first responders, it is important to remind them this. Mr. Rogers continuously tries to educate first responders on this matter:

I always try to tell people we see people at the worst of their addiction. When they are *disenfranchised* and *marginalized* in society. We never see them back when they are in school when they are back you know with people and etcetera. And we see them when they are committing crime and doing other things that generally society says is bad.

In addition to keeping an open mind, this participant also educates people on the brain chemistry, dose effect and neurochemical side of addiction in substance use disorder.

Besides education in the public health field, two participants mention communities they have worked with to reduce stigmatization of substance users. Ms. Morgan, the project coordinator for Healthy Guilford, mentions doing so through town hall meetings, in addition to neighborhoods when an overdose transpires. The narrative given can be morphed into such a way that wealthy neighborhoods will care more and

project less judgement. One participant explains the narrative she uses when speaking to these populations:

Yeah...It's not just your bum on the street. These are your cheerleaders in your schools, your straight A students. We try to make them aware and be like oh gosh that could be in my household or in my family. So, we try to make them aware it's not always the person that's homeless on the street.

Mr. Rogers also recounts his interaction with an older population:

I literally went and spoke to the Shepherd Center which is a group of retired adults in the community and I would guess the average age is in their 70s and 80s and if you told me 30 something years ago when I first started my career that I would be standing in front of 80 year old's talking about people shooting smack in our community I would tell you you're crazy. So, I think my role is to try and educate the community on the why the issue of that addiction can occur to anyone and it can occur to any family.

In addition to educating the public on the ability for the opioid epidemic to impact all populations, it is also important to educate people on the risk or likelihood that *they* could become addicted:

And you know the statistics are fairly, fairly strong so if you have one addictive parent you are six times more likely to have addiction issues in adulthood or actually in adolescence. If both parents are addictive then you have a 75 percent chance of having issues.

One *salient* reason education is important and valid is because when we understand addiction and how it occurs, we can treat it in a way that will provide the greatest outcomes.

Peer Support and Relationship Building

The narrative used when interacting with active users can work to further stigmatize them or it can be beneficial. Knowing how to speak with active users can make a significant difference. The following will show three different forms of peer support and/or relationship building.

The first account is a participant explaining his change in narrative when speaking with active users in the field as a paramedic:

I had a tendency to be very ministerial and patriarchal to people when reversing them especially if they are the age of my children and I'm a parent and I can't separate that from me as the provider but I had a tendency to have that kind of overtone of you're lucky to be alive because you're using drugs and I have really found that is not a positive way to guide them in the right direction.

Mr. Stokes, the justice involved coordinator, uses his knowledge on substance use disorder from personal life experiences to gain inmates trust resulting in him being able to better advocate for them. This participant also mentions several studies have shown it doesn't matter what kind of techniques a person uses; what really makes the difference is the relationship you have with the person. The following is what Mr. Stokes details in regards to connecting users to advocates with shared experiences:

I think because we've had a lot of similar experience. I can't say we share the exact same feelings but I do know that from the...from my own experience interacting with people with addiction or substance use disorder they just kind of get it a little more.

Further, I ask him, when people first enter the jail and are asked about substance use if they are informed, they would be able to speak to someone with lived or shared

experiences. Furthermore, if he thinks it would make a difference if they are not currently informed. He replies by agreeing that yes, this would make a difference, but unfortunately, they are not told that the person speaking with them would have shared experiences. If the inmate knew they would be speaking with someone having shared experiences, they potentially could feel more comfortable and unveil their problems with substance use.

The third scenario is one that details success and what can be accomplished when someone with lived experiences reaches out to current users. The program coordinator for GCSTOP has an outreach program in addition to the harm reduction services. After someone has experienced an overdose, a paramedic will ask if they are okay being contacted by someone with lived experiences. Those who agree, are contacted by the Mr. Perry, who will provide information on different treatment options. Through shared stories he has been able to connect on a separate level than someone without lived experiences.

These scenarios show all three participants using their past experiences, but in different ways. It is vital to understand both, the resources available and the reality of substance use and what it entails.

C.U.R.E. Triad vs. Professional Lives

Nonmaterial resources are the sole requirement for the accomplishments of C.U.R.E. Triad. Knowledge on resources available and the necessary access points are the sole importance for succeeding according to the vision of the organization. Participants have individually been able to achieve the goals set by C.U.R.E. Triad. This

has occurred all while C.U.R.E. undergoes the need to rebuild. The main resource that is causing a downward trajectory in the livelihood of this organization is funding. The difficulties of not having a sole person to answer phone calls and do administrative tasks is what has put C.U.R.E. into a stage of relaunching and rebranding.

Similar to within the organization, nonmaterial resources are the upmost importance in the accomplishments that members set for themselves. Regardless of the accomplishments made with nonmaterial resources, funding is still significant to the larger missions set by participants. Funding seemed to hit harder in the members professional lives resulting from the resources needed. Accessing treatment, building more facilities, funding naloxone availability, all of these goals heavily rely on funding that C.U.R.E. Triad doesn't personally have to contribute.

In conclusion, C.U.R.E. as an organization has been unsuccessful in helping with the limitations outside of the group. This may be true, but an important contribution that has been made to the success of goals set by individual members has been made possible through the meeting space provided by the group. Networking is one of the most beneficial accomplishments I observed in this research. Participants mentioned how they have met people they wouldn't have if not for C.U.R.E. Triad bringing them together. Not only has it brought people together that otherwise wouldn't have met, but it allows for the power some members have in the community to be accessed by others with considerably less power. Whether political or economic power, there have been several events that participants have valued the relationships made with other members of C.U.R.E. Triad. Letting one another know what events are being held increases the

turnout of the event, and ultimately, the man power used to educate the public on the opioid epidemic. A brief description of the events mentioned throughout the interviews can be found in table 4.

Table 4. Events Utilizing Connections

Name of Event	Description
UNCG Night at Greensboro Grasshoppers	Chancellor Gilliam attended the game and announced the starting line ups. All UNCG students, alumni, faculty and staff got discounted tickets. Raffles given out during every inning.
Medicine Take-Back Days	People come and drop off old and unused medications.
Pain Symposium	An entire day, broken up into different sessions, detailing different ways of tackling pain besides prescription pills.
Empowering Women in Recovery Tea	Tea to show what recovery looks like and empower recovery. The proceeds from the tickets go towards scholarships for treatment at Fellowship Hall.
International Overdose Day Rally for Change in Raleigh	Rally that remembers those lost to overdose, while at the same time advocating for recovery and positive change.

Many of these events are shared with one another through two main avenues. The first, on the agendas passed out at the C.U.R.E. Triad meetings. A screenshot showing upcoming events, mentioned by members of the group, can be found in figure 2.

Figure 2. Event Information from Agenda

<p>2. Event Calendar Update's</p> <p>Please email to curetriad@gmail.com to be added to the CURE website and google calendar</p> <p>A) ADS mentioned that they were in the process for planning for International Overdose Awareness Day on 8/25 or 8/26. The event will take place in partnership with the Greensboro Grasshoppers at a game.</p> <p>B) UNCG Spartan Recovery Program discussed an event they are planning for September which is National Recovery Month. The community will be asked to share photos of loved ones they have lost. These photos will be put on display on a wall in Student Union (Elliott Center).</p> <p>C) APNC (Addiction Professionals of North Carolina) will be hosting a training on Fetal Alcohol Syndrome. This will take place on 8/27 from 9:00 AM - 1:00 PM at Freedom House in Chapel Hill.</p> <p>D) ENCAPTA (spelling?) would be hosting a rally in Raleigh on 8/31 from 5:00 PM - 8:30 PM to bring attention to the issue of drug abuse. A rally will be held on the steps of the Capital and a candlelight vigil.</p> <p>E) October 26 a 5K called Maddy's Miles would take place near Hwy 68 in High Point.</p>	All	9:02am-9:08am
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The second avenue that people inform one another about upcoming events is through C.U.R.E. Triads Facebook page. Figure 3 is a screenshot from a post found on the C.U.R.E. Triad Facebook page.

Figure 3. Event Information from Facebook Page



In sum, my findings show that there is still a lot to be accomplished to take full control over the opioid epidemic. One of the more challenging tasks will be changing the narrative of how substance users are perceived. Some might question if this is even attainable, my participants included:

Uhm, putting a face to the issue, a human face to the issue, is the only way we're going to ever overcome the stigma. We will never overcome it 100 percent.

It is important to stay hopeful and be reminded of the accomplishments reached thus far, and the services currently being provided. In the discussion, I will revisit what is currently being done in the community, what is still being challenged, and through a resource mobilization framework, I will suggest what has brought about these changes.

CHAPTER V

DISCUSSION/CONCLUSION

C.U.R.E. Triad

Prior to conducting face-to-face interviews with members belonging to C.U.R.E. Triad, I had several hypotheses about what I would find. Accurately, I was under the impression the members had strong driving factors leading them to participate in the group – factors such as lived experiences, lost loved ones, and career aspirations. This assumption was in part from being exposed to the organization prior to the study. The other part was influenced from the literature (Jenkins 1983) which argues there is collective interests prior to coming together to form an organization,

Additionally, I anticipated the organization would provide aid to the C.U.R.E. Triad members to mobilize resources for their professional goals. The existing literature (Diani 1992) argues that leaders with former political experiences, professionals, and strong organizations are needed for a social movement group to succeed in mobilization efforts. In spite of the fact that C.U.R.E. Triad has engaged professionals with political connections as well as multiple well-known agencies, the organization has struggled to mobilize.

Instead of the organization aiding to member's professional endeavors, I found that C.U.R.E. Triad has been unsuccessful in both helping in the member's professional lives and in developing as a group. The inability of the organization to continue

developing relates to multiple factors: cost and benefit analysis, the lack of infrastructure and different opinions on how to reduce opioid related fatalities.

Formation of C.U.R.E. Triad

More than half the participants interviewed reported a personal motivation for wanting to participate in mitigating the opioid epidemic. Although only some participants had personal connections, every participant was motivated by professional interests. Grievances and career aspirations encourage members to join. After a member has joined, cost and benefits analysis influence ongoing participation (Klandermans 1984).

Unfortunately, participants motivated by their career alone, are likely to value expected outcomes less than members with personal connections (Klandermans 1984). Over time, members might no longer view their participation as important. This would lead to the member exiting the group along with the resources they provide to the organization. For example, after roughly two years, representatives from the Greensboro Police Department decided to no longer participate in C.U.R.E. Triad. Once they stopped actively participating, the meeting space provided by them would no longer be assessable.

Klandermans (1984) discusses the important contribution participation has on mobilizing resources. The more members in an organization, the greater likelihood of successful mobilization (Klandermans 1984). Indeed, an organization with a centralized structure would benefit significantly from additional participation.¹¹ However, C.U.R.E.

¹¹ In the literature review I described a centralized structure as an organization with members having specific roles and duties.

Triad initially had a decentralized structure when participation skyrocketed. The following section covers more on the structure of the organization.

Structure of C.U.R.E. Triad

C.U.R.E. Triad experienced multiple changes in the structure of the organization throughout its development. The first generation was characterized by a very lenient and flexible design. More stability was developed during the second generation when the mission, vision, and steering committee were formed. The organization started to lose focus on the mission of C.U.R.E. Triad when trying to put a formal structure in place.

Unfortunately, the transition to a formal structure wasn't fast-paced enough to avoid internal conflict. New members started challenging the overall intentions of the organization. There was agreement on the broader goal of getting people into recovery, but differing opinions on how exactly to do that. Without conducting further analyses, I can only assume the differing opinions is explained in part by the participants having diverse demographics.

Indeed, participants had collective identity in their role of mitigating the opioid epidemic. On the other hand, participants have different backgrounds – lived experiences are one example – that contribute to their values, morals, and ultimately, their perspectives. Some scholars (Diani 1992, Jenkins 1983, and McCarthy and Zald 1977) argue social movement organizations are made up of different agencies, organizations, and professionals. None of these scholars highlight potential challenges from members having diverse backgrounds. Scholars might understand more about the structure of social movement organizations when they take such challenges into account.

Understanding the structure of an organization can better inform scholars on what leads to successful mobilization.

Mobilization of Resources

Analyses show that C.U.R.E. Triad mobilized non-material resources far more than material resources. The organization was dependent on external groups (government agencies) for material resources. Furthermore, the only resource available to all generations was participants' knowledge of the opioid epidemic. I expected the organization would be less reliant on outside agencies for mobilizing material resources.

The literature (Klandermans 1984, Jenkins 1983, McCarthy and Zald 1977, and Corrigan-Brown 2016) argues members with prior political experiences, well-known agencies, and professionals can help successfully mobilize resources. Scholars refer to these representatives as "elites". Different categories of elite status are not discussed in resource mobilization literature. Distinguishing among members with access to non-material resources and those with material resources can contribute to understanding the success of social movement organizations.

The dilemma of gaining access to only one type of resource was addressed by Hunter and Staggenborg (1988). When an organization depends on economic capital, they can still succeed with abundant human capital. Members of C.U.R.E. Triad also have abundant non-material resources with far fewer material resources. Because there is dependence on material resources in both cases, the organization is unable to help mobilize in the professional lives of members.

Potential Mobilization

Networks

Several committee members have already been able to work together and achieve goals outside the organization. If given the opportunity members could benefit from working with each other. Below I spend a moment analyzing the impact C.U.R.E. triad could contribute to individual occupations. Understanding what mobilization could look like can help us to understand the potential achievements. In addition, these examples re-emphasize the importance of an organization's structure.

The organization provided space for networking without the appropriate structure to facilitate it. For instance, Ms. Russell is the only substance abuse coordinator for Guilford County Schools. If unlimited funds were made available, she would place peer-led support clubs in each Guilford County School. Whereas Mr. Hodges mentioned one of his greatest challenges in mitigation has been gaining access to schools. Early in the fourth generation, C.U.R.E.'s larger group broke into smaller groups. These groups were based on whether their individual initiatives dealt with prevention, intervention, or recovery. Breaking into those three smaller units would allow people like Mr. Hodges and Ms. Russell to work together.

In an interview with Ms. Luna, she expressed difficulties with pregnant women not showing interest in prenatal care, let alone treatment. Arguably, stigmatization and fear cause more disregard for care than disinterest. Speaking with Mr. Perry, through his outreach program, about treatment and harm reduction options might increase the chance of getting help. People with lived experiences are aware of the narrative needed to avoid

further stigma. This is yet another example of how networking can help reduce challenges faced by members of C.U.R.E. Triad.

Members Professional Initiatives

C.U.R.E. Triad members were clearly passionate and motivated to mitigate the opioid crisis. Regardless of their motivation, members were unable to mobilize material resources in response to funding limitations and political obstacles. These difficulties can be expected when relying on external sources (Corrigall-Brown 2016). However, there have been a few political opportunities helping aid mobilization to some extent. Participants described using their knowledge of available treatment and harm reduction options to assist active users seeking help.

Participants gained knowledge and expertise on addiction and the opioid epidemic through life experiences and their careers. I expected participants to use their knowledge but did not foresee how much they did. Although I didn't expect the importance of non-material resources to be so exponential, it's far from unjustified. Different treatment requirements, payments types accepted by different facilities, and where to access harm reduction methods are only three specific topics that may be confusing.

Advocating

One of the more significant aspects of mitigating the opioid epidemic is helping advocate for those in active use. I don't think any of my participants would disagree. Although warranted, there were specific reasons participants focused on guidance rather than other goals.

Funding

Making connections to external political and well-respected agencies can benefit organizations with limited material resources (Hunter and Staggenborg 1988). Potential sources of revenue can come from charitable events, governments and corporations (Corrigall-Brown 2016). Making these connections is central to the success of a social movement (Corrigall-Brown 2016). For example, proceeds from the Women in Recovery Tea event were used to finance scholarships for treatment at Fellowship Hall. The development of GCSTOP is an example of government agencies providing funds. Senator Trudy Wade received funding from bipartisan legislation in the general assembly that allowed for the creation of GCSTOP.

Although funds were received from different elite avenues, funding constraints described in the findings section describe challenges expected when relying on external revenue (Corrigall-Brown 2016). Limited access to economic capital for tangible resources created a gap. Participants have attempted to fill this gap with intangible resources, such as knowledge.

Hunter and Staggenborg (1988) argue that resources can determine the type of collective action members engage in. Moreover, with less economic resources, more “direct action” will occur such as rallies, demonstrations, sit-ins, etc. As described in the literature, multiple participants described their work as directly hands-on. One instance is providing information on the resources available for any given situation at hand. In addition, members described setting up tents at various rallies, sporting events, and others

like these. Hunter and Staggenborg (1988) agree that activists with limited economic resources have human capital no matter how underdeveloped.

Knowledge

Everyone who participated in this study had knowledge of the opioid epidemic. Participants mentioned at least one challenge arising from a lack of knowledge. Multiple participants mentioned the narrative used when talking to active users. Narratives can further stigmatize addiction and members in society who have substance use disorder. Understanding what narrative to use can increase the likelihood of community members seeking treatment and harm reduction methods.

The narrative used when talking with active users can make an astronomical difference in how the user responds. Mr. Stokes described speaking with incarcerated users on a personal level through his life experiences. To offer an alternative example: over the years, Mr. Rogers' realized that speaking to overdose victims in a patriarchal mannerism was a negative way to handle the situation. Through this awareness he reduced the amount of stigma he contributed and ultimately led to positive results.

The ability for first responders to speak in a respectful and compassionate manner to users on the scene of an overdose is important for GCSTOP to succeed. While attending to the overdose victim's needs, they will be asked by first responders if they would like to be contacted by someone with lived experiences. In addition to helping active users, Mr. Perry, the GCSTOP coordinator, speaks to first responders about the myths and facts of harm reduction, drug addiction and the barriers preventing substance

users from getting help. The amount of stigma placed on drug use shows how important education is when mitigating this epidemic.

I have grown increasingly disillusioned with opinions surrounding this social issue. Many folks in the general population still have misguided beliefs that addiction is a choice. Adding to this is an opinion that people with substance use disorder are deserving of the outcome it yields. This is not accurate and has been fought hard by several of my participants. Whether through the narrative used when speaking with people in active use, or by educating first responders and other challenging populations, the participants in this study have worked tirelessly to reduce the stigma placed on people who use. Additionally, professionals in the political and public safety sectors have begun reconsidering their perspectives on addiction being a choice.

Theoretical Framework

I was able to critically think about how the criminal justice, public health, and political sectors impact mitigating the opioid epidemic differently. Understanding how these sectors both challenge and help to mitigate the opioid epidemic was made possible through a resource mobilization lens. There are several themes not yet interpreted with this theoretical lens. This is the objective of the section that follows.

Redefining Grievances

Jenkins (1983) emphasizes the ability for elites to redefine long-term grievances. Policies making naloxone more readily available and allowing for syringe exchange programs are two methods developed with the rise in opioid overdoses. Initiatives targeting heroin-related overdoses became important once overprescribing opioids was

reduced (Rigg and Monnat 2015). Furthermore, community members with more social and economic status begun using heroin (Rigg and Monnat 2015). The increase in heroin use resulted in harm reduction methods that original heroin users have access to. Moreover, overprescribing has resulted in community members of diverse populations gaining access to such resources.

Prison facilities are another area where perspectives are being redefined. Although substance users continue to be incarcerated, many participants argue for setting up treatment programs in these facilities. Elites affected by the same problem as other community members have begun to change the narrative of addiction. New perspectives have initiated doubt for the war on drugs. Those previously impacted were unable to mobilize resources on their own (Hunter and Staggenborg 1988). I hope that this input can encourage such initiatives in the future before the problem spreads.

Public Health

According to everyone, the current public health system is also underdeveloped and lacks the appropriate resources to fully combat the opioid epidemic. This is visible with the lack of detox beds (especially for pregnant women) and the limited number of syringe exchange programs. Flaws in the public health system were stressed by observing which resources were easily mobilized and which were not.

The social movement literature does not explain additional possibilities when larger organizations and agencies lack resources to mobilize. Future research can help guide insight into mobilization when accounting for this limitation. There are also gaps in the literature for political opportunities and influences.

Political Influence

One of the major elements of resource mobilization theory is the impact politics and the political arena have on mobilization. My study is no exception, having both positive and negative responses from political policies. Negative responses can be viewed in policy implementation and funding restrictions. Some populations can benefit more from political influence than others. I provide examples of this argument in the following paragraphs. Future research on this could help to explain why some populations are impacted more than others by social problems.

Policy Implementation

Policy reforms have greatly improved members' actions. One example is the implementation of a syringe exchange program. The growing development of policy in support of syringe exchange programs has made this possible.

Former Governor of North Carolina, Pat McCrory, implemented a bill in 2015 that created a pilot study allowing several counties to develop syringe exchange programs. This implementation led to legalizing syringe exchange programs a year later, and eventually in 2019 making it legal to purchase syringes with government funds. In hindsight, all this implementation is beneficial. However, one might question, why did it take several years to legalize the use of government funds to purchase syringes?

Political influence through policy implementation will not always help initiate mobilization in social movements. A newer law, Death by Distribution reduces the likelihood of users calling 911 in the event of an overdose. It can be expected that this

policy will lead to more opioid-related deaths. In the paragraphs below, I will mention other overlooked aspects of policy implementation.

Missing Pieces from Implementation

Implementing public policies is a fair beginning to alleviate the opioid epidemic. Unfortunately, there are gaps in certain policies that cause substance users to avoid treatment due to further stigmatization and fear. The fear of being charged with homicide in accordance with the Death by Distribution law was previously mentioned.

Additionally, there are two other scenarios from my findings.

There are standing orders in North Carolina (Senate Bill 20) helping to aid naloxone accessibility. Stigmatization can limit this achievement. Mr. Stokes was denied the purchase of naloxone at a pharmacy because of social stigma on drug users' appearances. Nondiscrimination amendments could help reduce the stigmatization that active users experience.

The significance of additional OB/GYN prescribers who can administer medicine-assisted treatment to pregnant women is a topic in the North Carolina Action Plan (ncdhhs 2017). Additional OB/GYN prescribers could indeed help, however, the issue of stigmatization and fear will remain. Ms. Luna mentioned the fear that women have about their baby being taken out of their care once they are born can prevent them from seeking prenatal care, let alone treatment. Therefore, there is a need for more qualified OB/GYN prescribers. It would be useful for them to also have lived experiences. Talking to a doctor with lived experiences could ease the fear and reduce stigma on the expecting mother.

Not being able to speak with political decision-makers was a limitation in this study. This could provide insight into the missing parts of policy implementation. For now, in the section that follows, I will provide further limitations of my study, in addition to justifications.

Limitations and Justifications

The inability to interview community members in the political sector was mentioned as a limitation. Mobilization of resources heavily relies on policies, political opportunities, and connections to legislatures for support and funding (Hunter and Staggenborg 1988). It would have benefited my research to compare insight from people in the political sector to other sectors.

Another limitation in this study was the inability to interview anyone from law enforcement. When I first attended a C.U.R.E. triad meeting, there were two Greensboro Police Department representatives who were no longer part of the steering committee, nor the group altogether, by the time I conducted interviews. This is another area that has impact on the mobilization of resources. I could have benefited particularly from the information detailed in response to the criminal justice related questions.

The opioid epidemic has been an ongoing concern during this research. Within the past several years, multiple well-known actors, artists, athletes and others, have died from opioid-related overdoses. Prince, Tom Petty, MLB pitcher Tyler Skaggs and North Carolina Judge Tom Jarrell, all have passed from opioid fatalities within the last five years. These deaths likely have contributed to redefining drug addiction.

Applying theoretical perspectives such as resource mobilization theory allows scholars to study ongoing and future societal issues. Drug use has traditionally been addressed by the criminal justice system. This has proven to be ineffective over the years. Drug addiction has been traditionally addressed in the public health field. The political influence on active users seeking treatment has been overlooked as a result.

I was able to highlight the political influences on mitigation, the limited resources for treatment and harm reduction by using resource mobilization theory. This was all while understanding how community members come together to discuss a mutual concern in their community. Knowing what avenues to take and sources to vie from can help remain prepared before the next drug epidemic begins.

Future Research

In addition to the limitations of this research, future studies on social movement organizations working to mitigate drug epidemics could benefit from a social control theoretical framework. Using a theory on social control might help answer several additional questions. First, how has the measures taken to combat the opioid epidemic addressed the use of illicit and non-illicit drugs differently? Second, are some of the policies being implemented helping provide resources to some and creating systematic racism for others? Mr. Perry mentioned the Death by Distribution law was implemented to “protect the rich white boy that’s buying heroin from these black drug dealers.” Therefore, is it appropriate to assume political leaders are in fact aware of the myths and realities behind drug abuse and addiction?

Conclusion

The aim of this research was to understand how members of the Piedmont Triad area came together and formed a local organization (C.U.R.E. Triad), to mitigate the opioid crisis. I was also interested in identifying how, if any, C.U.R.E. Triad helped the members of the group mobilize resources for their own professional accomplishments.

The interviews with members of the community-based organization indicate that professional ties, and personal grievances, both brought the participants together. Members often cross paths in their professional lives but have no real space for colleagues to discuss community concerns. Proving a space to develop strong bonds and connections was the only true contribution C.U.R.E. Triad had.

Results indicate economic capital was challenging to mobilize both inside the organization and outside, in the members' professional careers. Because C.U.R.E. Triad was dependent on human capital the organization was unable to benefit the objectives members set for themselves. Advocating for active users by helping guide them through the resources readily available, or arguably unavailable, is the most pivotal actions seen in this study.

Understanding respondents' concerns for funding can help to inform future studies of social movements. Participants reported challenges in mobilizing funding from external sources (mainly governmental agencies) while also working to reform policies of those very funding agencies. The difficulties are expected to continue as the discrepancies within the multiple fields involved (addiction, politics, emergency services,

etc.). Everyone has a focus on guiding substance users to recovery, but people from different generations, careers and backgrounds visualize this in different ways.

Unfortunately, I found more difficulties than achievements while studying what is being done to mitigate the opioid epidemic. For instance, some people think there is absolutely no place for criminal justice in addiction, while others disagree. Regardless of whether this is true, it is in my opinion this study has contributed to conversations on drug use and drug addiction.

As a society, we continue to prescribe medications for any pain or illness. One of my participants said, “pain has become a fifth vital sign”, and this points to the importance of finding innovative methods of reducing drug fatalities for the future. It’s vital these initiatives are non-punitive and politically supported in order to successfully mobilize resources.

George Carlin said, “some people see the glass half full. Others see it half empty. I see a glass that’s twice as big as it needs to be.” This reference represents two pivotal takeaways from this study. First, there are several prospects for interpreting solutions to social problems. I was able to look at solutions from several disciplines by using resource mobilization theory. The additional theories I propose incorporating in future research concludes the importance of using multiple lenses. Second, when given two options, look for a third that analyzes both. Moving away from addressing the opioid epidemic as a criminal justice concern to a problem rooted in the public health system are the two options. The third more appropriate choice was to analyze and draw on the inequalities of both.

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https://www.drugs.com/celebrity_deaths.html

<https://www.curetriad.com/>¹²

¹² At the time of conducting research the website for CURE Triad was active. Since then, the website appears to have been taken down. I have still included this reference to use for in-text citing. I attempted to contact the individual who created the website and received no response.

APPENDIX A
INTERVIEW PROTOCOL

1. Can you tell me a little about your job? What is your job title?
2. What does a typical work day look like for you?
3. How did you first hear about C.U.R.E. Triad and how long have you been part of the organization?
4. How did you come to be involved in the organization?
5. What, in your opinion, are the strengths of C.U.R.E. Triad? And, in turn, can you identify any weaknesses in the program's areas or practices that could be improved?
6. From your vantage point, how has the C.U.R.E. Triad changed over time?
7. What methods or techniques do members in C.U.R.E. Triad use to inform the public and one another about their goals and accomplishments in mitigating the opioid epidemic?
8. What role do you and/or your occupation play in addressing the opioid epidemic?
9. Besides your occupational expertise, is there any personal/voluntary work that you do to contribute to mitigating the opioid epidemic? (peer support groups, parent support groups, etc.)
10. What is the greatest challenge you encounter with regards to your role in mitigating the opioid epidemic?
11. What tangible and/or intangible (money, facilities, knowledge, etc.) resources do you use most in addressing the problem?

12. What resources do you not have that would help to dissolve these challenges?
13. How, if any, has being part of C.U.R.E. Triad helped you move past some of these challenges?
14. How or how aren't all aspects of the opioid epidemic are being addressed in the community? If not, what is being unaddressed?
15. What policies contribute to the ability or inability of addressing the aspects of the opioid crisis?
16. How is the opioid epidemic being addressed as either a criminal justice concern, a public health problem or both?
17. How has this changed, if any, over time?

Thank you for your time and insight on this matter.

APPENDIX B

DEMOGRAPHICS QUESTIONNAIRE

1. How would you classify your gender?
 - a. Male
 - b. Female
 - c. Prefer not to say
 - d. Non-Binary
2. How would you classify your racial identity?
 - a. White or Caucasian
 - b. Black or African American
 - c. Asian
 - d. Native Indian or Alaska Native
 - e. Native Hawaiian or Other Pacific Islander
3. What is your current age? _____
4. What is your educational background?
 - a. Less than a High-School Diploma
 - b. High-school diploma
 - c. Some College, No Degree
 - d. Associate Degree
 - e. Bachelor's Degree
 - f. Master's Degree
 - g. Doctoral Degree

APPENDIX C

SUBSTANCE USE PREVENTION CALENDAR

September	Responsible Decision Making (K-5) S.M.A.R.T Recruitment & Kick Off (6-12)
October	Red Ribbon Week (October 24 th – 31 st) (K-12) National Substance Abuse Prevention Awareness Month
November	Vaping & Tobacco Prevention (K-12) Great American Smoke Out (November 21)
December	Healthy Friendship & Giving (K-5) Media Literacy: Messages in Advertising (6-12) National 3D Prevention Month: Drunk & Drugged Driving
January	Healthy Choices (K-5) Marijuana / Synthetic Marijuana Prevention (6-12) National Drug & Alcohol Facts Week (January 21 st – 26 th)
February	Medicine Safety (K-5) Over-the-Counter Medication/Prescription Drug Misuse Prevention (6-12)
March	Household Product Safety (K-5) Inhalant Prevention (6-12) Kick Butts Day (March 20) <i>HS Only: Club Drugs/Hallucinogens</i>
April	Alcohol Prevention (K-12) National Alcohol Awareness Month <i>HS Only: Safe & Sober Prom</i>
May/June	Making S.M.A.R.T. Choices (K-12) <i>HS Only: Graduation</i>